Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-19-049

Prepared by: New York State Office of Children & Family Services

Issue Date: Mar 12, 2020

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 11 year(s)
Jurisdiction: St. Lawrence
Gender: Female
Date of Death: 10/04/2019
Initial Date OCFS Notified: 10/07/2019

Presenting Information

A 7065-Agency Reporting Form noted on 10/4/19, at approximately 6:55 AM, the child was being driven to school by her cousin. Their vehicle was struck by another vehicle and flipped over as a result. The child was pronounced deceased from her injuries.

Executive Summary

This fatality report concerns the death of an 11-year-old female who died on 10/04/2019. The child died during an open Family Assessment Response (FAR) that was opened after a report was made to the SCR regarding concerns for the child's living conditions and lack of food. Reported concerns also included the mother and grandmother's health negatively impacted their abilities to adequately care for the child. There were no surviving siblings or other children living in the home.

On 10/4/19, St. Lawrence County Department of Social Services (SLCDSS) received information from law enforcement that the child was killed in a car accident on the same day. The child's relative was driving her to school when their vehicle was struck by another vehicle. The collision was a result of the other vehicle running a stop sign.

An autopsy was performed, and the medical examiner's report listed the manner of death as accidental and the cause of death as "cerebral avulsion due to multiple skull fractures due to blunt force trauma."

At the time of the child's death, she temporarily resided with her aunt and the aunt's mother per a family agreement. The child's permanent residence was with her mother and grandmother. The child's father was predeceased. SLCDSS offered an abundance of services to the child's grandmother and aunt in response to the death. The record did not reflect the mother was spoken with during the open case or in response to the death. Although home visits were made, according to the grandmother, the mother would not speak with the caseworker. As a result of SLCDSS not being able to meet with the mother, SLCDSS was not able to directly offer services to her.

PIP Requirement
SLCDSS will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the SLCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SLCDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A

- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The child died during an open FAR case and a determination was not required. The Safety Assessment and Risk Assessment Profile were not required to be completed at the time of case closure as there were no surviving children.

Was the decision to close the case appropriate? N/A
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The case record did not reflect all casework activity was completed prior to case closure. The record did not reflect the mother was interviewed regarding the SCR report or fatal incident.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/04/2019 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 06:55 AM

County where fatality incident occurred: St. Lawrence
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

☐ Sleeping ☐ Working ☒ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	11 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	66 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)

LDSS Response

On 10/4/19, SLCDSS learned from law enforcement the child died as a result of a car accident on the same day. Law enforcement said the child was riding in her cousin's vehicle at approximately 6:55 AM when their vehicle was struck by a vehicle running through a stop sign. The impact caused the vehicle the child was in roll over. The child was pronounced deceased as a result of her injuries.

Upon learning of the child's death, SLCDSS immediately notified the Syracuse Regional Office by completing the 7065-Agency Report Form. The death was not a result of alleged child abuse or maltreatment; therefore, no SCR report was required.

On 10/11/19, SLCDSS made a home visit to the case address and met with the grandmother. Referrals for hospice services were provided to the grandmother. The grandmother said the mother was in her bedroom at the time of the home visit, but would not speak with the caseworker; therefore, SLCDSS did not directly offer services to her in response to the death or speak with her about the Family Assessment Response. The record reflected the mother had pre-existing mental health challenges and was involved in mental health services prior to the child's death.

Throughout the FAR track, the caseworker appropriately engaged the grandmother, and provided referrals for an abundance of services, including financial assistance. The caseworker partnered with the grandmother adequately; however, the record did not reflect the mother was engaged during the FAR track. SLCDSS learned from the grandmother that the mother was utilizing mental health services. The grandmother did not know if she herself was ready to talk about the fatality. The FAR track was closed on 12/2/20.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: St. Lawrence County has an OCFS-approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☒	☐	☐	☐	☐	☐	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐

Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The grandmother was offered an abundance of services and referrals were made in response to the fatality as well as other unrelated needs of the family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The grandmother was provided with information regarding referrals for services in response to the fatality. The mother was engaged in mental health counseling at the time of the death; however, the record did not reflect the mother was offered other services in response to the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/30/2019	Deceased Child, Female, 11 Years	Mother, Female, 34 Years	Inadequate Food / Clothing / Shelter	Far-Closed	Yes
	Deceased Child, Female, 11 Years	Mother, Female, 34 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Female, 11 Years	Grandparent, Female, 66 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Deceased Child, Female, 11 Years	Grandparent, Female, 66 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report alleged the mother and grandmother's home was a health and safety hazard for the child. The home had a foul odor from dog feces and cat urine. There were dirty dishes and clutter. Due to the clutter, it would be difficult for the family to leave quickly in an emergency. There was not ample food in the home. The mother suffered from mental health

challenges and had a history of suicide attempts, which affected her ability to properly care for the child. On 9/28/19, the mother attempted to overdose on psychiatric medication. The grandmother suffered from a heart condition and was not in good health, which affected her ability to properly care for the child.

OCFS Review Results:
SLCDSS initiated the SCR report timely and appropriately tracked it FAR. The source of the report and relevant collateral contacts were made. SLCDSS did not properly engage the family in the Family Assessment Response as documentation did not reflect the mother was spoken to. Written notification of the SCR report was not provided timely. The 7-day Safety Assessment was completed timely and accurately and a CPS history check was documented timely.

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:
FAR-Failure to Provide Notice of Report
Summary:
Although written notice of the SCR report was provided to the family, the family was not provided with the notice within 7 days of the SCR report.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
No later than seven days after receipt of a child protective report that has been assigned to the Family Assessment Response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Issue:
FAR-Overall Completeness/Adequacy of Family Assessment Response
Summary:
As the mother was not spoken with, the reported concerns were not addressed with her and she was not engaged in the FAR track or consent to the SCR report being tracked FAR. Although the grandmother reported she understood the FAR track, the record did not reflect she agreed to FAR.
Legal Reference:
18 NYCRR 432.13 (a)(1-4)
Action:
All parents, children and other persons listed on the SCR report will agree to the FAR track and will be engaged throughout the Family Assessment Response. The family's agreement to the FAR track will be clearly documented in the case record. When identified, SLCDSS will make appropriate referrals to benefit the family.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/19/2019	Deceased Child, Female, 11 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	No

Report Summary:
An SCR report alleged the mother had a history of substance abuse and mental health challenges. She heard voices and had multiple inpatient mental health hospitalizations. The mother continued to abuse substances and had mental health challenges while the sole caretaker of the child. On 6/19/19, the mother was under the influence of drugs and alcohol and had drug residue around her mouth and teeth. She mumbled and acted erratically while hallucinating. The mother was not able to adequately care for the child.

Report Determination: Unfounded | **Date of Determination:** 09/06/2019

Basis for Determination:
The allegation of Parent Drug/Alcohol Abuse was unsubstantiated against the mother regarding the child. The investigation revealed the mother was abusing medication she was not prescribed; however, no credible evidence was revealed that she was abusing medication/drugs in the presence of or while caring for the child. SLCDSS found no credible evidence to support the mother's drug use had a negative impact on the child.

OCFS Review Results:
SLCDSS initiated the investigation timely. The source of the report was contacted and a CPS history check was documented. Multiple home visits were made and there was an ongoing assessment of safety. The family and collateral contacts were interviewed. The Safety Assessments and Risk Assessment Profile were completed accurately.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/08/2017	Deceased Child, Female, 9 Years	Mother, Female, 31 Years	Inadequate Guardianship	Far-Closed	No
	Deceased Child, Female, 9 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Deceased Child, Female, 9 Years	Aunt/Uncle, Male, 19 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Female, 9 Years	Aunt/Uncle, Male, 19 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Deceased Child, Female, 9 Years	Grandparent, Female, 65 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Female, 9 Years	Grandparent, Female, 65 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
An SCR report alleged the mother, grandmother and uncle drank alcohol and used drugs to impairment while caring for the child. While the adults were impaired by alcohol and drugs, they were unable to care for the child. The adults sold drugs from the home where the child resided. It was unknown if the child had access to drugs.

OCFS Review Results:
The case was immediately initiated by contacting the source of the report. A CPS history check was documented. Several home visits were made to assess safety, the family was interviewed and collateral contacts were made. The case was appropriately tracked FAR and the FLAG was completed with the family.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

CPS - Investigative History More Than Three Years Prior to the Fatality

11/24/14- 2/9/15- IG was unsubstantiated against the father regarding the child.

6/14/15- 9/15/15- The parents were unsubstantiated for IG, L/B/W and PD/AM. The mother was unsubstantiated for SA and LMC regarding the child.

10/18/15- 1/13/16- The parents were substantiated for IG and PD/AM and unsubstantiated for LMC and SA regarding the child.

8/21/16- 10/15/16- The mother and grandmother were unsubstantiated for IG regarding the child.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Preventive Services History

A Preventive Service case was opened on 1/12/16 after the family was referred by a CPS worker. The family was struggling with addictions and mental health challenges. The parents needed assistance becoming involved with community-based services. Although face-to-face contacts were made, the progress notes did not reflect conversations with the child regarding the reason for caseworker involvement or any potential concerns for her safety. The father agreed to close the Preventive Services case as the family's goals were met. The father was sober and able to care for the child. The case was closed on 5/2/16.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No