Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-22-040

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

Issue Date: Feb 24, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 5 year(s)
Jurisdiction: Madison
Gender: Male
Date of Death: 09/03/2022
Initial Date OCFS Notified: 09/03/2022

Presenting Information

The SCR report alleged that on 9/3/22 around 1:30PM, the mother drove with the subject child and sibling in the vehicle. The mother crossed over the lane and struck another vehicle head-on. The subject child was found outside of the vehicle and sustained unknown injuries. The subject child succumbed to his injuries at the time of the accident. It was unknown if the subject child was appropriately restrained in the vehicle. The sibling sustained an open left frontal skull fracture, bilateral fractures to his tibia and fibula, and a contusion to his chest from the seat belt. Law enforcement and emergency medical services responded to the scene. The mother and sibling were transported to the hospital. The sibling was flown to another hospital for a higher level of care. The subject child was pronounced deceased at the scene of the accident. A subsequent report was received on 9/27/22, with concern about the maternal grandmother being under the influence while caring for the sibling.

Executive Summary

This fatality report concerns the death of a 5-year-old male subject child that occurred on 9/3/22. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, Internal Injuries, Fractures, and Lacerations/Bruises/Welts against the mother. A subsequent report was received on 9/27/22 with allegations of Inadequate Guardianship and Parent's Drug / Alcohol Misuse against the maternal grandmother. At the time of his death, the subject child resided with his mother and 1-year-old surviving sibling. The father had unstable housing and did not reside with the subject child.

Madison County Department of Social Services (MCDSS) completed collateral and casework contacts and learned that on 9/3/22, the mother was driving with the subject child and sibling in her vehicle. The mother crossed the centerline of her lane, and collided head-on with an oncoming vehicle. The subject child was ejected from the vehicle and pronounced dead at the scene of the accident. The sibling sustained a skull fracture and bilateral tibia fractures. The mother sustained numerous injuries as a result of the accident and was placed on a ventilator. The mother remained unresponsive for approximately two weeks after the accident.

An autopsy was performed; the preliminary cause of death was listed as atlantooccipital joint dislocation resulting from a car crash and the manner was determined to be accident. The preliminary findings showed evidence that the subject child was restrained by seat belts. The final autopsy was not provided to MCDSS, pending the open criminal investigation.

Bereavement services were offered on behalf of the surviving sibling. Referrals were made to community-based services on behalf of the sibling and maternal grandparents. All allegations against the mother and maternal grandmother were unsubstantiated. MCDSS made a safety plan for the sibling to be discharged from the hospital to the father; however, the father violated the plan by allowing his girlfriend to have contact with the sibling against a previously established court order, and the sibling was informally placed in the care of the maternal grandparents. The mother was transferred from the hospital to a rehabilitation center and gave guardianship of the sibling to the maternal grandparents. The CPS investigation was unfounded and closed on 10/27/22.

PIP Requirement
This review resulted in a citation related to casework practice. In response, MCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the MCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, MCDSS will review the plan(s)

and revise as needed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
MCDSS made an appropriate determination based on the evidence obtained throughout their investigation.

Was the decision to close the case appropriate? Yes

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:
Casework was not commensurate with case circumstances. MCDSS did not review safe sleep guidelines with the BF's friend, who was utilized as a safety resource and determined to be pregnant.

Required Actions Related to the Fatality

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

Issue:	Failure to provide safe sleep education/information
Summary:	The record did not reflect that safe sleep was discussed with the BF's friend who was utilized as a safety resource, despite knowledge that she was pregnant.
Legal Reference:	13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1
Action:	MCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/03/2022 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 01:30 PM

County where fatality incident occurred: Oneida
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 and/or ingested alcohol or drugs? N/A
Child's activity at time of incident:

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

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	Alleged Victim	Male	5 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	54 Year(s)
Other Household 1	Grandparent	No Role	Male	57 Year(s)
Other Household 2	Father	No Role	Male	28 Year(s)
Other Household 2	Father's Partner	No Role	Female	27 Year(s)

LDSS Response

Upon receipt of the SCR report, MCDSS coordinated their efforts with law enforcement, spoke with collateral sources, completed a CPS history check, and interviewed family members.

MCDSS was initially unable to interview the SM, as she was unresponsive for at least two weeks following the accident. When the SM became responsive, she was unable to remember the accident or provide details about the events preceding the SC's death. The SM was told numerous times that the SC had perished in the accident; however, could not retain this information and continued to speak about the SC in present tense.

LE stated the SM crossed the center line and hit another vehicle head-on. Two individuals in the other vehicle also died because of injuries sustained during the accident. After reconstructing the accident, LE reported that the SC was in a low back booster seat, which he met the height and weight requirements for. LE noted the seat belt was likely toward the SC's neck which made it ineffective during the accident and the SC may have survived in a high back booster seat. The SS was in a forward-facing five-point harness, but the retractor was not locked. There were no signs of intoxication or impairment by the SM; therefore, LE was unable to obtain a search warrant for a toxicology on the SM. MCDSS learned that the SM had preexisting medical conditions and underwent brain surgery prior to the fatal event. Although medical records from the SM's doctors were received, it was unknown what impact these prior treatments might have had on the SM's ability to operate a vehicle.

While the SM was unresponsive, a safety plan was put in place that the SS would be discharged to the BF after his treatment in the hospital, on the condition there was no contact with the BF's girlfriend due to a previously established custody order. Immediately after discharge, the BF had the SS in the presence of his girlfriend, violating the safety plan. MCDSS made a new safety plan with the BF, that the SS would be in the care of the maternal grandparents, where he remained until the SM gave guardianship to the grandparents at the time of case closure.

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 investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: Madison County Department of Social Services referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062572 - Deceased Child, Male, 5 Yrs	062600 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
062572 - Deceased Child, Male, 5 Yrs	062600 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
062599 - Sibling, Male, 1 Year(s)	062600 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
062599 - Sibling, Male, 1 Year(s)	062600 - Mother, Female, 27 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
062599 - Sibling, Male, 1 Year(s)	062601 - Grandparent, Female, 54 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
062599 - Sibling, Male, 1 Year(s)	062600 - Mother, Female, 27 Year(s)	Fractures	Unsubstantiated
062599 - Sibling, Male, 1 Year(s)	062600 - Mother, Female, 27 Year(s)	Internal Injuries	Unsubstantiated
062599 - Sibling, Male, 1 Year(s)	062601 - Grandparent, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
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?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to

				Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: Referrals were made on behalf of the SS and the MGM accepted community-based services.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: In-home Community Based Services							
Additional information, if necessary: Referrals were made on behalf of the SS for trauma therapy. The MGM accepted referrals to community-based services to assist in caring for the SS until the SM was able to do so.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
Services were offered on behalf of the SS. At the time the CPS case closed, the SS was engaged in trauma therapy and referral to developmental/educational services had been made.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to family regarding the SC's death. The MGM accepted community services to assist in the care of the SS. The SM met with a psychiatrist on multiple occasions during her hospitalization.

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)	Allegation Outcome	Compliance Issue(s)
06/25/2020	Deceased Child, Male, 3 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 3	Mother, Female, 25	Lack of Supervision	Unsubstantiated	

Years	Years		
Deceased Child, Male, 3 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 3 Years	Father, Male, 26 Years	Lack of Supervision	Unsubstantiated

Report Summary:
The SCR report alleged that in April 2020, the SM placed the SC on the roof of a car and walked away, leaving the SC unattended and unsupervised with a high risk of injury. The SM and BF left the SC outside without supervision. The SC was seen running across the street and playing on the curb of the street without supervision.

Report Determination: Unfounded | **Date of Determination:** 07/22/2020

Basis for Determination:
MCDSS determined there was no credible evidence to substantiate the allegations. There were no police records regarding the SC playing outside alone or being unsupervised. All collateral contacts denied seeing or knowing the SC was left unsupervised. The SM and BF said they had a history of domestic violence, but the BF sought counseling last year and there were no incidents for the last year. CPS case was unfounded and closed with no services, which the family declined.

OCFS Review Results:
MCDSS initiated their investigation within 24 hours by completing a home visit and meeting with all individuals listed on the report. MCDSS spoke to numerous collateral contacts and completed the safety assessments timely, and accurately. The CPS history check was documented late and there was no documentation in the case record that the adults listed on the report were notified of the report in writing. MCDSS was made aware that the SM was pregnant; however, the record did not reflect that safe sleep information was discussed or provided.

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

Issue:
Review of CPS History
Summary:
The CPS history was documented late on 7/13/20.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, MCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, MCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Failure to provide notice of report
Summary:
There was no documentation that the SM and BF were provided Notice of Existence letters or made aware of the report in writing.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
MCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:
Failure to provide safe sleep education/information
Summary:

MCDSS was made aware that the SM was pregnant during their investigation; however, the record did not reflect that safe sleep information was provided or that safe sleep provisions were documented.

Legal Reference:

13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:

MCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The Risk Assessment Profile did not reflect a history of domestic violence, despite law enforcement responding to the SM and BF's residence on two occasions for verbal and physical altercations.

Legal Reference:

18 NYCRR 432.2(d)

Action:

MCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

[redacted]

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known history outside of NYS.

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