Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-17-009

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

Issue Date: Aug 22, 2017

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		
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
CPR-Cardiopulmonary Resuscitation		
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

Case Information

Report Type: Child Deceased
Age: 9 year(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 04/17/2017
Initial Date OCFS Notified: 04/17/2017

Presenting Information

An SCR report was received which alleged on 4/17/2017 at approximately 6:00 AM, the SM and her two children, ages 9 and 11, were passengers in a car and were not restrained. The car veered over the median of the road, hit a guardrail, and flipped over multiple times. Both children were ejected from the car. One of the children was then hit by another oncoming car. Both children were pronounced dead at the scene. Since it was unknown what relationship the driver of the vehicle had with the children, he could not be considered a person legally responsible at the time of the intake report. It was unknown whether drugs, alcohol, speed, or reckless driving were factors in the accident.

Executive Summary

On 4/17/2017, Erie County Department of Social Services (ECDSS) received an SCR report concerning the death of the SC and his 11-year-old sibling. Within 24 hours of the report, ECDSS learned the SM and CHN were sleeping passengers in a car being driven by SM's friend. A fatal car crash ensued which took the lives of both CHN. The driver was seriously injured and remained in critical condition throughout the investigation. The SM was also hurt, but her injuries were not life-threatening.

The family and SM's friend were traveling west-bound on the New York State Thruway towards their destination in Erie County where they all resided. At 5:45 AM that morning near Clifton Springs NY, the 31-year-old male driver likely fell asleep at the wheel and the car veered into the guard rail, rolling multiple times before landing in between the grass and the roadway. SM was the only conscious survivor, and kicked her way out through the windshield. She found both her CHN in the roadway, as they had been ejected from the vehicle. SM found the sibling about 20 steps away, and it was determined he had been struck by another vehicle after he was ejected. New York State troopers and EMS responded immediately, and noted the CHN showed "obvious signs of death" upon their arrival. Both the SM and the driver of the vehicle were transported to a hospital in Rochester, NY.

ECDSS spoke with the Coroner and requested a copy of the autopsy report, though it was not received by the time of the writing of this report.

Coordination was made between ECDSS and 3 other counties, assigned secondary roles due to locations of the family. The incident occurred in Ontario County where CHN were transported to the morgue. Monroe County Department of Human Services (MCDHS) was assigned due to location of the hospital, and ACS was assigned due to the location of BF's residence.

SM was interviewed, and her fiancé who resided with her and the CHN was briefly spoken with as well. ACS spoke with the BF at the request of ECDSS, and attempted to assess his home. The BF was described as sad and minimally engaging, and declined ACS access into his home. Both parents reported the boys were their only CHN. Diligent efforts were made to interview the driver of the vehicle. ECDSS periodically spoke with hospital staff and at each contact, he remained in the Intensive Care Unit in critical condition, unable to be interviewed.

MCDHS interviewed the SM at the hospital, and ECDSS interviewed her in her home after she was discharged. Based on observations and contacts with collaterals, ECDSS found no signs of abuse or maltreatment of the CHN. SM was consistent in her account that she was adamant about seatbelt use with the CHN. To her knowledge, the CHN wore their

seatbelts the entirety of the trip, and buckled themselves in the backseat after a brief stop at a rest area at approximately 3:00 AM. She was unaware they had removed their seatbelts. Collaterals suggested the CHN were not buckled in based on the fact they were ejected from the vehicle. For these reasons, allegations were unsubstantiated against the SM. ECDSS thoroughly inquired as to whether the driver of the vehicle was a person legally responsible for the CHN. He was found to have never had any caretaking responsibilities for the CHN; therefore, he was determined not to be legally responsible and no allegations were added against him.

SM was interested in bereavement services and ECDSS offered them as well as information on Mobile Crisis. BF was offered similar services in his area though he declined, citing he was already receiving counseling.

ECDSS closed the CPS investigation after making the determination to UNF the report. No further CPS interventions were required as there were no surviving CHN. ECDSS' actions and decisions during this investigation were reflective of best casework practices. ECDSS and the 3 secondary counties assigned to the investigation worked well together across jurisdictions.

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?** 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:
The safety decision on all safety assessments reflected that safety factors existed at the time of case closing but required no safety plan. No safety factors should have been selected, as there were no surviving children upon which to assess lingering safety factors.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The level of casework activity was commensurate with case circumstances. There were several detailed notes of supervisory consultation, not only in ECDSS but amongst inter-agency staff in counties assigned a secondary role.

Required Actions Related to the Fatality

Child Fatality Report

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/17/2017 **Time of Death:** 05:45 AM

County where fatality incident occurred: Ontario
Was 911 or local emergency number called? Yes
Time of Call: 05:47 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
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
How long before incident was the child last seen by caretaker? 3 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

☐ Drug Impaired ☐ Absent
☐ Alcohol Impaired ☒ Asleep
☐ Distracted ☐ Impaired by illness
☐ Impaired by disability ☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 2
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	9 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	29 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	11 Year(s)
Other Household 1	Father	No Role	Male	34 Year(s)
Other Household 2	Other Adult - Driver of vehicle, mother's friend	No Role	Male	31 Year(s)

LDSS Response

Within 24 hours of the SCR report, ECDSS coordinated with other counties assigned secondary roles, as well as with LE. ECDSS learned the children's bodies were transported to the morgue of a nearby hospital, and the SM as well as the driver of the vehicle were flown to a hospital in Rochester, New York.

First responders, including LE, informed ECDSS the children were deceased upon their arrival and were considered killed on impact. The children had been back seat passengers in the car and were un-buckled. The car hit the guard rail and rolled multiple times. When the children were ejected from the vehicle upon impact, they were also hit by an oncoming vehicle. LE noted it appeared the driver may have fallen asleep. LE stated they were not aware of either adult being under the influence of drugs or alcohol. The driver was in grave condition from skull fractures sustained from the impact. The SM was later treated for 3rd degree burns, a sprained spine in her neck, and lacerations. She also sustained a head injury without concussion.

The driver remained hospitalized in critical condition throughout the length of the investigation. ECDSS frequently inquired as to his status, and for medical reasons, were never able to interview him. ECDSS learned information about the events leading up to the accident from the SM. SM stated she and the boys were returning from visiting their BF in Brooklyn, New York for spring break and had left to return home on 4/16/2017 around 11:00 PM. She decided to allow a friend to carpool, as they resided in the same city and could share driving on the long trip. SM had no reason to think he was an incompetent driver, and she denied either of them were under the influence of drugs or alcohol. SM and the children slept in the car while the other adult drove. Around 3:00 AM, the SC's sibling woke up the SM, stating he needed to throw up. They stopped at a nearby rest area, and were back on the road shortly thereafter. SM stated the next time she awoke, the car had jerked and proceeded to roll/flip. She found the children in the roadway after she made her way out of the vehicle. The driver was unconscious.

ECDSS coordinated an interview between ACS and the BF. His account of the day prior to the incident was consistent with that of the SM. Despite ACS' efforts, he was only minimally engaged based on his apparent grief over the loss of his children.

ECDSS was thorough in their collection of information from collateral contacts, which included first responders, LE, family members, the children's school and pediatrician, and medical providers. ECDSS appropriately determined there was no credible evidence to substantiate the allegations of DOA/Fatality and IG regarding the children against the SM, as she consistently stated she was adamant about seatbelt use and had no knowledge that the children were not properly restrained in the car. There was no indication SM was responsible for any of the events leading up to the death of the children.

All assessments were completed timely and accurately, and the case was appropriately determined and closed.

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: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in Erie County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039881 - Deceased Child, Male, 9 Yrs	039883 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
039881 - Deceased Child, Male, 9 Yrs	039883 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
039901 - Sibling, Male, 11 Year(s)	039883 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
039901 - Sibling, Male, 11 Year(s)	039883 - Mother, Female, 34 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?	☒	☐	☐	☐

Additional information:

The vehicle driver remained in critical condition throughout the case. ECDSS made diligent efforts to interview him by speaking periodically with medical staff for updates on his wellbeing. Due to his condition, he was never able to be interviewed.

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	Needed but not Offered	Needed but Unavaliable	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	☐	☐	☐	☐	☐	☒	☐

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? N/A
Explain:
There were no surviving children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered to the parents. BF declined and identified his own resources. SM accepted information offered, though the record doesn't reflect any direct services that were provided while the case was open.

History Prior to the Fatality

Child Fatality Report

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	No
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

There is no CPS investigative history in NYS within three years prior to the fatality.

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

CPS investigation dated 10/19/2012-12/18/2012 alleged EdN against SM regarding the SC's sibling who was 7 years old at the time. The report was UNF.

CPS investigation dated 9/28/2013-5/14/2014 alleged IG against SM and several other adults in the home regarding the SC, the SC's sibling, and 6 unrelated children in the home. The report was IND against SM and the other adults.

Known CPS History Outside of NYS

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

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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

Additional Local District Comments

We appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality.

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