



Report Identification Number: RO-19-025

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

Issue Date: Nov 15, 2019

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		



Case Information

Report Type: Child Deceased
Age: 3 year(s)

Jurisdiction: Monroe
Gender: Male

Date of Death: 07/15/2019
Initial Date OCFS Notified: 07/15/2019

Presenting Information

On 7/15/19, two reports were made to the SCR regarding the death of the three-year-old male subject child. The mother worked her morning shift at a coffee shop with her child present. The child followed the mother around the coffee shop while she worked. The mother exited out of the back of the coffee shop to throw out boxes and the child followed. Near the back door, there was a grease pit with a loose manhole cover on it. The mother was not properly supervising the child while he was outside. As a result, the child stepped on the loose cover and fell into a six foot deep hole. The child was submerged in four and a half feet of grease and drowned. The mother was unable to find the child for approximately 10-15 minutes. 911 was called and EMS responded and performed CPR on the child, but were unsuccessful. The child was pronounced deceased around 12:00 PM.

Executive Summary

This fatality report concerns the death of the three-year-old subject child who died on 7/15/19. Two reports regarding the death were made to the SCR on the same day. The child resided with his mother, great aunt and uncle. There was an eight-year-old sibling who resided in North Carolina. The sibling was assessed to be safe in the care of his mother.

Monroe County Department of Human Services (MCDHS) coordinated investigative efforts with law enforcement upon receipt of the report. It remained unknown if any criminal charges were filed regarding the death. An autopsy was performed, and the medical examiner declared the manner of death was accident and the cause was drowning.

The mother reported bringing the child to work with her at a coffee shop on 7/15/19. She took boxes outside and the child was following behind her. Within seconds, the mother turned around and could not find the child. She notified her co-workers, and they began to look for the child, who was found floating in the coffee shop's grease trap. He was unresponsive and not breathing. It was reported the lid was not properly closed, which allowed the child to fall into the trap.

911 was called and co-workers and bystanders performed CPR until first responders arrived and took over resuscitation efforts. The child was transported to the hospital, where he was pronounced deceased at 12:00 PM.

MCDHS gathered information regarding the death from law enforcement, hospital staff, witnesses, family members and first responders.

MCHDS learned the mother moved out of the home with the great aunt and uncle. The family members were provided with referrals for bereavement services, grief counseling and burial assistance; however, it was unknown if the family utilized the services.

MCDHS unsubstantiated the allegations of Inadequate Guardianship, Lack of Supervision and DOA/Fatality regarding the child. The investigation did not reveal credible evidence the mother was aware the grease trap was not properly secured, and she was providing appropriate supervision to the child when he fell into the trap. MCDHS completed the required Safety Assessments and reports timely and accurately and conducted a thorough investigation.

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:

Casework activity was commensurate with case circumstances.

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 decision to close the case was appropriate.

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: 07/15/2019

Time of Death: 12:00 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Monroe

Was 911 or local emergency number called? Yes



Time of Call:

10:59 AM

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
- Playing
- Other

- Working
- Eating

- Driving / Vehicle occupant
- Unknown

Did child have supervision at time of incident leading to death? Yes

At time of incident supervisor was: Not 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	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Other Adult - Great Aunt	No Role	Female	58 Year(s)
Deceased Child's Household	Other Adult - Great Uncle	No Role	Male	64 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)

LDSS Response

On 7/15/19, MCDHS received the fatality reports from the SCR and immediately initiated their investigation. Within the first 24 hours of receiving the report, MCDHS contacted the sources of the reports, coordinated investigative efforts with law enforcement, completed a CPS history check and interviewed the mother and family members.

The mother was interviewed at the hospital on 7/15/19. The mother said she went to work at a coffee shop around 9:15 AM that day and brought the child with her as she did not have childcare available. It was reported the child had gone to work with his mother in the past and was well behaved. The mother brought boxes outside of the shop, and the child followed behind her. She put the boxes down and when she turned around, the child was gone. She immediately notified her coworkers and bystanders, and everyone was searching for the child. The child was found unresponsive in a grease trap, which was not properly closed or secured. The grease trap was located in a grassy area next to the parking lot and was several feet deep.

The witnesses reported the mother alerted them the child was missing, and everyone began to look. A coffee shop worker said he immediately thought of the grease trap and went outside with a broom. He put the broom stick into the grease trap, but did not feel anything. Another worker saw clothing and the child was pulled from the trap, 911 was called at 10:59 AM, and CPR was initiated. EMS responded, took over resuscitation efforts and transported the child to the hospital via ambulance.

Medical staff reported the child arrived at the hospital in cardiopulmonary arrest and did not have external injuries. CPR was performed for a half hour before the child was pronounced deceased at 12:00 PM.



Law enforcement provided MCHDS with video surveillance of the incident. The video showed the child walking behind the mother as she was carrying boxes. Law enforcement said the child was in “direct eye sight and proximity” to the mother. Within 10 seconds of having her back to the child, she turned around and noticed the child was missing and immediately began looking for him. Video surveillance showed the child stepping on to the grease trap and the lid flipping open, which resulted in him falling in. The child was found within 10 minutes of falling into the grease trap.

Family members reported they had no concerns for the care the mother provided to the child. The great aunt and uncle were interviewed at home. They did not have information regarding the death and said the mother had not returned home after the incident. They did not have concerns for the care the mother provided to the child.

On 8/20/19, MCDHS made contact with the father of the child, who resided in North Carolina. It was learned the child had an eight-year-old surviving sibling. The father was offered bereavement services, it was unknown if he utilized the services. The sibling resided with his mother in North Carolina and his safety was appropriately assessed through a phone call.

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 reviewed by an OCFS approved Child Fatality Review Team? Yes

Comments: The death was referred to the Child Fatality Review Team during the course of the investigation.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051809 - Deceased Child, Male, 3 Yrs	051810 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
051809 - Deceased Child, Male, 3 Yrs	051810 - Mother, Female, 27 Year(s)	Lack of Supervision	Unsubstantiated
051809 - Deceased Child, Male, 3 Yrs	051810 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Child Fatality Report

All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

The father was not interviewed face-to-face; however, he resided in North Carolina and was not a subject of the report. The father was appropriately interviewed by phone.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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Explain:
At the times the 24-hour and 7-day Safety Assessments were due, MCDHS was not aware of the surviving sibling who resided in North Carolina. The surviving sibling did not have a relationship with the subject child.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Alcohol/Substance abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Child Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Intensive case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family or others as safety resources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

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? No

Explain:

The sibling resided in North Carolina and did not have a relationship with the child. His safety was appropriately assessed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine

Explain:

The family was offered an abundance of services; however, it remained unknown if the services were utilized.

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

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

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

Known CPS History Outside of NYS

A CPS investigation was held in North Carolina during February 2018. The investigation was determined to be eligible for a Family Assessment Response, and there was no determination. Although MCDHS requested the records, they were unclear. An order of protection was granted; however, the record was not clear if it was to protect the mother or the child from the father. Supervised visitation was ordered regarding the father and child. There were no concerns for the mother's ability to care for the child.



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