Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-19-002

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

Issue Date: Jun 20, 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: 9 year(s)
Jurisdiction: Niagara
Gender: Female
Date of Death: 01/01/2019
Initial Date OCFS Notified: 01/02/2019

Presenting Information

An SCR report was received with concerns the child suffered from diabetes, and the mother was failing to meet the child's medical needs; as a result, the child died. There were further allegations the mother was abusing substances while caring for the children.

Executive Summary

This fatality report concerns the death of a 9-year-old female subject child (SC) that occurred on 1/1/19. A report was made to the SCR on 1/2/19, with allegations of Inadequate Guardianship, Lack of Medical Care, Parent's Drug/Alcohol Misuse, and DOA/Fatality against the child's mother (SM) and her boyfriend, the parent substitute (PS). Niagara County Department of Social Services (NCDSS) received the report and investigated the child's death. An autopsy was completed, but the cause and manner of death remained pending at the time of this writing; however, the medical examiner informed NCDSS the child's cause of death was most likely due to "untreated diabetes."

At the time of the child's death, she resided with her mother, two surviving siblings (SS, ages 12 and 11) and two surviving half-siblings (ages 2 years and 8 months). The child's biological father did not reside in the home, nor did the parent substitute, although the parent substitute was spending the night on the date of the fatal incident.

The subject child suffered from diabetes mellitus and had been treated regularly for such at a pediatric diabetes clinic since she was 4 years old. The investigation revealed throughout her years attending the clinic, the parents failed to keep the child's condition under control, despite several trainings that were provided. It was discovered the child had been feeling ill since 12/30/18, and on 12/31/18, spent most of the day lying down, unable to eat. At approximately 1 PM, the mother checked the child's glucose level, and it was high; she reported to NCDSS that she then gave the child insulin. The child's condition did not improve throughout the day, so the mother asked the child if she wanted to go to the hospital; the child declined. That night, the child was unable to eat dinner and complained of feeling warm and cold. The mother got the child into bed around 9PM, and then went to bed herself shortly thereafter. The mother and parent substitute were awoken by the siblings sometime after midnight, after they had watched the New Year's Eve ball drop on TV, and the mother went to check on the child. At that time, the mother found the child in her bed, unresponsive. Emergency services were not called, rather the parent substitute brought the child to the hospital via his own vehicle stating he felt it would be quicker than waiting for an ambulance. Hospital staff tried to resuscitate the child but were unsuccessful. Her time of death was called at 2:32 AM on 1/1/19.

After an investigation by NCDSS and law enforcement, it was revealed via the child's glucose monitor history that the child's glucose levels were checked a total of 5 times throughout the day of her death. The child's levels were over 600; a normal glucose level would have been around 140. Her levels only decreased slightly over a period of several hours, which indicated it was likely no insulin was ever administered.

From the time the investigation began to the time of its closure, NCDSS met with and interviewed all individuals who were present at the time of the fatality, as well as assessed the safety of all surviving siblings and half-siblings. Several collateral sources were also spoken with. Appropriate services were offered in response to the child's death. A criminal investigation was opened and remained ongoing at the time of this writing. NCDSS found evidence to substantiate the allegations related to the child's death, and opened the case for preventive services; however, the record did not reflect if filing an Abuse/Neglect Petition was ever considered. No credible evidence was found regarding the allegations of

maltreatment involving the siblings. At the time of this writing, the family was continuing to engage in preventive services.

PIP Requirement
NCDSS will submit a Program Improvement Plan (PIP) to their Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) NCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, NCDSS will review the plan(s) and revise as needed to further address on-going concerns.

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:
NCDSS thoroughly investigated the death of SC; however, legal was not consulted when a petition would have been appropriate, nor did the final safety assessment reflect the seriousness of the concerns.

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:
NCDSS thoroughly investigated the events and facts surrounding SC's death. NCDSS appropriately substantiated the allegations in the report.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments

Summary:	The record reflected SC most likely died due to medical neglect. SM had an 8-month-old with a life-threatening illness, and services were needed to prevent placement of the SS. Safety decision #2 was not appropriate at the time of determination.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	Prior to making a determination, the investigation conducted by the child protective service shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment in the form and manner provided by OCFS.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	A Secondary Caretaker was not listed on the RAP. NCDSS only listed SM; however, SC's biological father had an active caretaker role in SC's life and was equally responsible for SC's diabetes care.
Legal Reference:	18 NYCRR 432.2(d)
Action:	NCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.
Issue:	Assessment as to need for Family Court Action
Summary:	The record reflected medical neglect directly contributed to SC's death; however, the record did not reflect NCDSS discussed these findings with their legal department, nor that filing a petition in family court was considered.
Legal Reference:	SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)
Action:	The child protective service worker shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/01/2019 **Time of Death:** 02:32 AM

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

County where fatality incident occurred: Niagara
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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

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	Female	9 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	12 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	11 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	8 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Other Household 1	Mother's Partner	No Role	Male	33 Year(s)
Other Household 2	Father	Alleged Perpetrator	Male	30 Year(s)
Other Household 3	Sibling	No Role	Male	4 Year(s)

LDSS Response

On 1/2/19, NCDSS received the SCR report regarding the death of SC, which occurred on 1/1/19. NCDSS initiated their investigation within 24 hours and coordinated their efforts with LE. NCDSS learned SC had diabetes mellitus, which was being monitored by a specialist. NCDSS also learned SC lived with her 2 SS (12 and 11 years old) and 2 half-siblings (2 years and 8 months old). SC had another half-sibling who was in foster care at the time of the incident and NCDSS assessed his safety; no concerns noted.

On 1/3/19, NCDSS interviewed the 2 SS. The 12yo reported he was not at home when the incident occurred, he was at his grandmother's. He said his grandmother told him SC was "very, very sick" and passed away during the night. The 12yo had no other information and expressed no safety concerns. The 11yo reported SC was very sick when she woke up on 12/31/18, so much so that she could not move. The 11yo explained SM gave SC her medication around noon that day, but not after dinner because SC would not eat. The 11yo stated SM put SC to bed, and the 11yo stayed up to watch the ball drop. Afterward, the 11yo woke up SM and PS and a few minutes later SM said SC had to go to the hospital. The 11yo stated her BF called her around 3 AM to tell her SC had passed away. The 11yo denied knowing anything else and reported no safety concerns.

On 1/3/19, NCDSS assessed the safety of the half-siblings and interviewed SM. SM stated SC had felt ill since 12/30/18. SM stated all day 12/31/19, SC "was feeling bad" and her sugar level was high. SM stated she asked SC if she needed to go to the hospital and SC stated no. SM stated she went to the store and when she returned, she found out SC had two cups of fruit punch while she was gone. SM stated she took SC's sugar level at 1 PM, and it was still high, so SM gave her insulin. SM said SC would not eat dinner, and SM put her to bed around 9PM. SM stated she and PS went to bed before midnight, and sometime between 12 AM and 2 AM, SM went to check on SC and found her unresponsive. SM had inconsistencies in her story regarding when she checked SC's sugar levels and when/how much insulin was given. A safety plan was put into place while the investigation continued.

On 1/4/19, NCDSS interviewed PS and SC's BF. According to BF, SC appeared "ok" during the brief time he saw her the

morning of 12/31/18; BF was not present when the fatal incident occurred. PS reported SC did not leave the couch that day, and was unable to eat dinner. PS stated he does not know anything about SC's diabetes, how to test SC's sugar or give insulin. He reported only SC and SM handled this. PS stated sometime after 12 AM, he was checking on the 8-month-old when he heard SM scream. PS stated he tried to wake SC, picked her up and drove her to the hospital. He stated the hospital "did all they could, but she was already gone."

On 1/4/19, NCDSS spoke with staff at SC's diabetes clinic. Staff reported SC had been a patient there since she was 4, and despite numerous trainings, BF and SM did not have SC's condition under control; her glucose levels were consistently in the 400s, when normal was around 140. Staff stated SC should have been brought to the hospital on 12/31/19.

On 1/11/19, NCDSS made the decision to lift the safety plan and allowed the CHN to return home to SM.

On 1/14/19, NCDSS discussed the case with their legal department and was advised to have the family engage in a 6-month preventive services case. On 1/25/19, NCDSS and LE reviewed the history stored in SC's glucose monitor. It showed SC's levels were over 600 on 12/31/19, and were tested 5 times throughout the day; medical staff determined no insulin was given. Despite this new information, NCDSS did not update their legal department or discuss filing a petition. NCDSS indicated the report against SM and BF, and opened the case for preventive services. A criminal investigation remained ongoing at the time of this writing.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical 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
Comments: This fatality investigation was conducted by the Niagara County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was reviewed by the Niagara County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050291 - Deceased Child, Female, 9 Yrs	050294 - Father, Male, 30 Year(s)	DOA / Fatality	Substantiated
050291 - Deceased Child, Female, 9 Yrs	050294 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
050291 - Deceased Child, Female, 9 Yrs	050294 - Father, Male, 30 Year(s)	Lack of Medical Care	Substantiated
050291 - Deceased Child, Female, 9 Yrs	050300 - Mother, Female, 28 Year(s)	DOA / Fatality	Substantiated
050291 - Deceased Child, Female, 9 Yrs	050300 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated

050291 - Deceased Child, Female, 9 Yrs	050300 - Mother, Female, 28 Year(s)	Lack of Medical Care	Substantiated
050295 - Sibling, Male, 12 Year(s)	050300 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
050295 - Sibling, Male, 12 Year(s)	050300 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
050296 - Sibling, Female, 11 Year(s)	050300 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
050296 - Sibling, Female, 11 Year(s)	050300 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
050297 - Sibling, Female, 2 Year(s)	050300 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
050297 - Sibling, Female, 2 Year(s)	050300 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
050298 - Sibling, Female, 8 Month(s)	050300 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
050298 - Sibling, Female, 8 Month(s)	050300 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	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:

NCDSS spoke with appropriate collateral sources to gather information surrounding the fatality and the safety of the siblings. Family members were interviewed regarding the incident.

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:
The parents had a long history of neglecting to control SC's diabetes, and SM had another child with a chronic, life-threatening disease at the time of this report. Although autopsy findings were not yet available, it was believed the parents' failure to provide an appropriate response to SC's high glucose levels played a significant role in her death. Despite this, NCDSS did not document any conversation with their legal department surrounding filing a petition against the parents.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: Although no siblings needed to be removed from the household, a Safety Plan was implemented for several days while the initial concerns were investigated.				

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: Preventive Services							

Additional information, if necessary:
Appropriate services were offered to the family, and a voluntary preventive services case was opened and ongoing at the time of this writing.

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:
NCDSS provided bereavement counseling referrals for the siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
NCDSS provided bereavement counseling and funeral expense referrals to the parents. A voluntary preventive services case was opened to address ongoing needs 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?	Yes

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)
10/13/2016	Deceased Child, Female, 7 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 7 Years	Mother, Female, 26 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Female, 7 Years	Mother, Female, 26 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 1 Days	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 1 Days	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
This report was received with concerns SM was not complying with SC's medical needs regarding her diabetes. There were further concerns SM was not supervising what SC was eating daily, and SC had not been to her diabetes specialist in five months. As a result, SC's glucose levels are high and she was at risk of hospitalization. Further, SM gave birth to the now 2 yo half-sibling and both SM and CH were positive for marijuana. The roles of BF and the SS were unknown.

Report Determination: Indicated | **Date of Determination:** 01/02/2017

Basis for Determination:
NCDSS interviewed SM and the verbal children, as well as SC's BF. NCDSS spoke with medical staff at SC's diabetes clinic as well as hospital staff where SM gave birth to the half-sibling. NCDSS also followed up with the CHN's pediatrician and schools. NCDSS found evidence to substantiate all allegations and closed the case.

OCFS Review Results:
This is the second indicated CPS report involving LMC regarding SC's diabetes. Serious concerns were expressed by providers and schools that the issues remained ongoing for years and parents remained noncompliant with SC's care. NCDSS did not offer preventive services or consult their legal department. NCDSS did not adequately interview the BF, nor add him as a subject. NCDSS did not follow up with the parents regarding concerns collateral sources expressed. The CPS history check was completed late. NCDSS closed the case without following up with the diabetes clinic to confirm SC made it to her 12/15/16 appointment, the parents attended the education class, and meal plans were provided.

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

Issue:
Review of CPS History
Summary:
The CPS history review was completed 4 days late.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, NCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child's sibling, and, for indicated reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
NCDSS was informed by school and medical that the parents have been non-compliant with SC's medical needs for years. Serious concerns were expressed by providers and NCDSS did not appropriately address them with the family. NCDSS did not follow up to confirm SC made it to her follow up appointment on 12/15/16, or if the parents attended the diabetes training class offered by the clinic.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
Prior to making a determination, NCDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
The interview with BF was inadequate. NCDSS failed to ask questions surrounding SC's medical needs/care, nor did they ask about SM's substance use. NCDSS did not ask BF who resided in his home; his CHN visited him regularly. NCDSS was informed SC had not been to her pediatrician since 2014, and a SS had not been since 2013; however, NCDSS failed to follow up with the parents regarding this.
Legal Reference:
432.1 (o)
Action:

NCDSS will make efforts to interview all persons named in a report, who may have been present during what was alleged in the report, and/or may have information pertinent to the safety and well-being of children that reside in the home.

Issue:
Assessment as to need for Family Court Action
Summary:
The family was IND for LMC in 2014, and a petition was previously filed against the parents for noncompliance with SC's medical needs. Concerns regarding SC's needs were again reported in 2015. The concerns have been present for several years throughout SC's life. NCDSS did not consider family court action nor consult their legal department to discuss options for this high-need family.
Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)
Action:
The child protective service worker shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:
Failure to offer services
Summary:
NCDSS did not discuss available services specific to the needs of the family. The family may have benefited from preventive services, parenting classes, and/or family planning services.
Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
NCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Appropriateness of allegation determination
Summary:
The BF was listed as having No Role on this case. BF was just as responsible for SC's care as SM, and he consistently failed to meet SC's medical needs. Allegations against BF should have been added and indicated.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
NCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

[redacted]

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

5/4/15: UNF for IG against SM and BF regarding SC.
3/6/14: IND for IG, LMC against SM and BF regarding SC.
2/18/14: UNF for IG, LS against SM regarding SC and the now 12 and 11 yo SS.
9/27/13: IND for IG against BF regarding SC and the now 12 and 11 yo SS.
8/5/13: UNF for IF/C/S and IG against SM regarding SC.
11/29/12: FAR case opened with allegations regarding IG, LS, PD/AM against SM and an unrelated adult regarding SC and the now 12 and 11 yo SS. Case was opened for services.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A mandated preventive case was opened in July 2014 due to concerns SC's diabetes was not being cared for appropriately by SM and BF. The case was closed on 1/6/15 due to the parents completing their court ordered services and meeting their goals.

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

There was a legal consult done regarding the updated glucose monitor information. The assigned caseworker left on a medical leave on 1/18/19 and did not enter the note. The caseworker did attempt to change the RAP to reflect the father as a secondary caseworker but was unable to make any change. The safety was reduced to #2 as the mother was compliant with our service requests at the time of closing especially with regards to the infant with the leukemia. The matter is still pending criminally as the autopsy has not been received by the District Attorney's office.

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