Child Fatality Report

Report Identification Number: SV-17-015

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

Issue Date: Nov 27, 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	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: 12 year(s)
Jurisdiction: Orange
Gender: Male
Date of Death: 05/27/2017
Initial Date OCFS Notified: 05/30/2017

Presenting Information

The 12-year-old SC had been sick since Thursday, 5/25/17. SC had a stomach ache and diarrhea and could not hold anything down. BM was aware but did not take SC to the doctor. On 5/27/17, BM left the home around 8AM and left SC to care for his 9yo sister (SS1) and 6yo brother (SS2), knowing he was unable to adequately care for them due to being sick. When BM arrived home at approximately 10:25AM, she found SC unresponsive on the couch. BM contacted 911 at 10:30AM and when first responders arrived, they declared SC deceased. The roles of BF and the 2yo twins (SS3 & SS4) were unknown.

Executive Summary

The SCR received a report on 5/27/17 alleging DOA/Fatality, IG, LMC, and LS against BM for the SC, as well as LS against BM for SS1 and SS2. Orange County Department of Social Services (OCDSS) began their investigation and coordinated efforts with LE upon receipt of this report. OCDSS saw all SS on this day and assessed their safety. The preventive CW had been in the home on 5/26/17 and noted that all the CHN were ill.

The investigation revealed that on 5/27/17, BM was awoken around 1:30AM by SC talking. BM reported the SC talked for almost 2 hours and he was not making any sense. BM gave him a drink and he eventually went to sleep. BM left the home for a meeting between 7:45 and 8AM, leaving SC, SS1, and SS2 home alone. SC had been ill with a contagious stomach virus since 5/24/17. BM was aware that SC was very ill and could not provide adequate supervision of his younger siblings. BM returned home around 10:30AM and saw SC in the same position as when she left. BM said one of the SS told her they saw SC get up and go to the bathroom while BM was gone. BM was later drug tested and the results were negative. There was no evidence of BM being under the influence of drugs or alcohol at the time of SC's death. SS3&4 were living with MGM at the time of the fatality.

The cause of death was unknown at the time. SS1 and SS2 were seen at the Dr. on 6/4/17 and were medically cleared. MGM brought SS3&4 to the Dr. on 6/5/17 and there were no medical concerns at the time of this appointment.

The family had been working with preventive services at the time of this fatality due to drug charges against BM.

The ME's autopsy examination revealed the preliminary cause of death was from a viral infection with complications from asthma and the manner was natural.

OCDSS appropriately unsubstantiated the allegations of DOA/Fatality & LMC stating lack of credible evidence. ME told OCDSS that there was no way to tell if SC's death could have been prevented had BM sought medical attention. The allegations of IG and LS were Sub. Investigation was IND and closed, and the case remained open for services.

Presently, SS3 and SS4 remain in the care of their MGM and BM is now living with them as well. SS1 and SS2 remain with their BF. BM receives substance abuse treatment and private therapy. SS1 and SS2 have been receiving preventive services.

OCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of receipt of this report.

This PIP will identify what action(s) OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS 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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	The father of the two youngest children was not provided notice of the SCR report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	Each subject and each adult "other person named" in the report, including non subject parents not actually listed in the report must receive a notification letter.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/27/2017 **Time of Death:** 03:57 PM

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

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? 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? No - but needed
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	12 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	6 Year(s)
Other Household 1	Father	No Role	Male	32 Year(s)

LDSS Response

OCDSS began an investigation upon receiving an SCR report on 5/27/17 regarding the death of SC. The family was receiving Preventive Services at the time of SC's death. OCDSS reviewed notes from the open case and discovered the Preventive worker had been to the home on 5/26/17. That worker had noted SC, SS1, and SS2 were ill.

The OCDSS CW went to the home on the date of the report. LE and family members were present. LE advised CW of the circumstances surrounding SC's death; the DA was notified. LE provided CW with statements from family and neighbors as well as criminal history for BM and BF.

The CW interviewed MGM and learned she returned SC, SS1, and SS2 to BM's care on 5/16/17 following BM's discharge from rehab 2 weeks prior. MGM continued to care for SS3 & SS4, and the siblings often visited at MGM's

home. MGM visited the BM's home on 5/26/17 and knew the CHN there had been sick all week. SS4 had also been sick. MGM verified SC had asthma.

In an interview with the BM, CW learned BM brought SS4 to the Dr. on 5/23/17. The Dr. said SS4 had a contagious stomach virus. CW verified this visit, documenting SS4 was seen for diarrhea and vomiting and BM was given instructions for care. BM stated SC had been ill since 5/24/17. BM gave SC Tylenol at 7:00 PM on 5/26/17 and reportedly spoke to him between 1:00 and 3:00 AM, when he presented as incoherent. The next morning, BM left the home between 7:45 and 8:00 AM, leaving SC, SS1, and SS2 home alone. BM thought she saw SC breathing before she left. Upon her return, SC was unresponsive. BM reported 1 of the SS said SC had gotten up while she was gone. BM was not under the influence of drugs or alcohol during the time the CHN were sick. OCDSS learned BM was on probation and had just received a shot so she could not become high from drugs.

CW and LE visited BF's home. SS2 was interviewed and reported the night before, SC laid on the couch, ate ice pops, and drank juice. SS2 said that night SC took a bath by himself. He had not seen his mother give SC medication. He reported SS1 was also sick and threw up. SS2 described the morning of 5/27/17, and said he saw SC on the couch sleeping. SS2 was not aware of his mother's absence that morning. When asked, SS2 knew what to do in case of an emergency. SS1 was then interviewed and confirmed similar accounts of the timing and description of the SC's illness. SS1 described SC as having vomited a lot the night before, and knew BM gave him medicine. SS1 noted BM responded to SC throughout the night. SS1 saw SC moving on the couch the next morning. SS1 called BM when she woke, as instructed by the note BM left. BM came home in response and checked on the CHN, at which point she found SC unresponsive. SS1 & SS2 went to stay with PGM that night. CW also saw SS3 & SS4 at a relative's home; they had not been present in the home at the time of the fatality.

CW learned BM went to the hospital for a MH assessment following the fatality. BM was admitted, and was discharged on 5/30/17. CW made follow-up home visits and saw the CHN on multiple occasions throughout the investigation.

OCDSS searched CPS history for all adults. The 24-hour safety assessment and both fatality reports were submitted and approved on time. Contact was made with several collaterals such as the ME, BM's probation officer, Drug Court, Catholic Charities, and the CHN's schools. A recording of the 911 call and copies of the CHN's medical records were received.

The investigation was closed after the appropriate determination was made to IND the report against BM. DOA/Fatality and LMC were appropriately unsub as the ME stated there was no way of knowing if SC may have survived had BM sought medical treatment. IG & LS were Sub as BM was aware SC was unable to supervise the SS. Upon the closing of the investigation, the family continued to receive Preventive Services.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a 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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
040901 - Deceased Child, Male, 12 Yrs	040902 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
040901 - Deceased Child, Male, 12 Yrs	040902 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
040901 - Deceased Child, Male, 12 Yrs	040902 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
040901 - Deceased Child, Male, 12 Yrs	040902 - Mother, Female, 30 Year(s)	Lack of Medical Care	Unsubstantiated
040904 - Sibling, Female, 9 Year(s)	040902 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
040905 - Sibling, Male, 6 Year(s)	040902 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated

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 safety 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	☒	☐	☐	☐

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: A neglect petition was filed against the BM. BF was granted temporary custody of SS1 and SS2.				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
06/01/2017	There was not a fact finding	There was not a disposition
Respondent:	040902 Mother Female 30 Year(s)	
Comments:	BF was given temporary custody of SS1 and SS2. BM was granted supervised visitation twice a week.	

Have any Orders of Protection been issued? Yes	
From: 06/01/2017	**To:** Unknown
Explain: OP issued (unspecified stay away or refrain from) against BM and MGM to protect SS1 and SS2. It's unclear why there was an OP issued against MGM. BM was allowed supervised visits with SS1 and SS2.	

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 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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

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?	Yes
Was the child ever placed outside of the home prior to the death?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
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)	Status/Outcome	Compliance Issue(s)
04/04/2017	Sibling, Female, 2 Years	Grandparent, Female, 60 Years	Inadequate Guardianship	Unfounded	Yes
	Deceased Child, Male, 12 Years	Grandparent, Female, 60 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 6 Years	Grandparent, Female, 60 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Female, 60 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 6 Years	Grandparent, Male, 60 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Male, 60 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Male, 60 Years	Lack of Supervision	Unfounded	
	Deceased Child, Male, 12 Years	Father, Male, 32 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 2 Years	Father, Male, 32 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 2 Years	Father, Male, 32 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Male, 60 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 2 Years	Father, Male, 32 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Male, 60 Years	Lacerations / Bruises / Welts	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Female, 60 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Male, 60 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Male, 60 Years	Sexual Abuse	Unfounded	

Sibling, Female, 9 Years	Grandparent, Female, 60 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 9 Years	Grandparent, Female, 60 Years	Lack of Supervision	Unfounded
Sibling, Male, 6 Years	Grandparent, Female, 60 Years	Inadequate Guardianship	Unfounded
Deceased Child, Male, 12 Years	Grandparent, Male, 60 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 9 Years	Grandparent, Male, 60 Years	Lack of Supervision	Unfounded
Sibling, Female, 9 Years	Father, Male, 32 Years	Lack of Supervision	Unfounded
Sibling, Male, 6 Years	Father, Male, 32 Years	Lack of Supervision	Unfounded
Sibling, Female, 9 Years	Grandparent, Male, 60 Years	Inadequate Guardianship	Unfounded
Deceased Child, Male, 12 Years	Grandparent, Female, 60 Years	Lack of Supervision	Unfounded
Sibling, Female, 2 Years	Grandparent, Female, 60 Years	Lack of Supervision	Unfounded
Deceased Child, Male, 12 Years	Grandparent, Male, 60 Years	Lack of Supervision	Unfounded
Sibling, Male, 6 Years	Grandparent, Male, 60 Years	Lack of Supervision	Unfounded
Deceased Child, Male, 12 Years	Father, Male, 32 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 9 Years	Father, Male, 32 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 6 Years	Father, Male, 32 Years	Inadequate Guardianship	Unfounded

Report Summary:
SS4 had a laceration and an abrasion on the outside of her vagina. SS4's injuries were suspicious in nature and the explanation was not consistent with the visible injuries. SS4 was in her grandfather's care when she sustained her injuries; therefore, grandfather was considered the alleged subject. Roles of MGM, SS3, SC, SS1, and SS2 were unknown.

Determination: Unfounded | **Date of Determination:** 05/24/2017

Basis for Determination:
SS4 had been constipated and had a piece of feces stuck that would not come out. The grandfather removed the piece of feces which is believed to have caused the bleeding. Grandfather and MGM took the CH to the hospital and hospital had no concerns of abuse/maltreatment. Emergency room doctor was interviewed and had no concerns of abuse and did not find any trauma. SS4's pediatrician had no concerns. Staff at the children's schools had no concerns. All of the children were interviewed and did not disclose any abuse/maltreatment. The Dr from the CAC felt the explanation was consistent with the injury.

OCFS Review Results:
Safety of all of the CHN was promptly assessed due to the seriousness of the allegations. OCDSS completed all casework on time, contacted several collaterals, and had thorough interviews with all of the children and alleged subjects. Father of the three oldest children was not provided with a notification letter of the SCR report.

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

Issue:
Failure to provide notice of report
Summary:
BF of the three oldest children was not provided with a notification letter of the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will notify each subject and each adult "other person named" in the report, including non-subject parents not actually listed in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/30/2017	Deceased Child, Male, 12 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Indicated	Yes
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 1 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 1 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Deceased Child, Male, 12 Years	Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 12 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 1 Years	Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 1 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 1 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Sibling, Female, 1 Years	Mother, Female, 30 Years	Inadequate Guardianship	Indicated	

Report Summary:
BM was on probation for possession of drugs. On 3/30/17, 10 bags of heroin, a bag of cocaine, and several drug paraphernalia were found in BM's home. BM admitted to using drugs. BM was the sole caretaker of the children. BM

was under the influence while caring for SC, SS1, SS2, SS3, and SS4. The house was filthy and in disarray with dirty clothing all over the home.

Determination: Indicated | **Date of Determination:** 05/18/2017

Basis for Determination:
BM admitted to the allegations and the children corroborated. BM admitted to her Probation Officer that she'd used drugs several times the week before, and also showed the probation officer her drugs. BM also had fake urine she intended to use for drug tests.

OCFS Review Results:
BM went to rehab in lieu of jail time. CHN were appropriately placed with their MGM at that time, and were safe and comfortable staying with their grandmother. CW consulted with legal about filing a neglect petition and it was decided the CHN were not in imminent risk so no petition would be filed. Case was appropriately indicated and opened to preventive services. BM agreed to drug court, preventive services, and MH treatment. BM completed 28 days of rehab and adhered to the discharge summary. All safety assessments were completed on time and appropriate services were offered and obtained. BF of the youngest children was not notified of the SCR report.

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

Issue:
Failure to provide notice of report

Summary:
OCDSS did not provide notification of the SCR report to the father (BF2) of the two youngest children (SS3 & SS4).

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
OCDSS will notify each subject and each adult "other person named" in the report, including non-subject parents not actually listed in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/07/2016	Deceased Child, Male, 12 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unfounded	No
	Sibling, Female, 8 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 8 Years	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 6 Years	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Female, 1 Years	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Female, 1 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 6 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 1 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 12 Years	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Unfounded	

	Sibling, Female, 1 Years	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Unfounded

Report Summary:
BM had a history of getting high on unknown types of prescription pills in the presence of SC, SS1, SS2, SS3, and SS4. The mother became too impaired to adequately care for the children as a result of the drug use. Roles of the other family members were unknown.

Determination: Unfounded | **Date of Determination:** 09/13/2016

Basis for Determination:
CW made an unannounced home visit and did not find BM to be impaired by any substances. BM had been taking pain medication for injuries suffered from a physical assault no longer takes them. CW interviewed all CHN and they made no disclosures of BM being impaired while caring for them. CW contacted several collaterals who had no concerns of BM becoming impaired while caring for the CHN. BM had a preventive worker who had frequent and regular contact with BM and the CHN. The preventive worker had no concerns.

OCFS Review Results:
CW never witnessed BM impaired from any substances, CW interviewed all parties, spoke to several collateral contacts including relatives and BM's preventive worker. BF was upset over the custody arrangement and was in the process of going back to Family Court for his children. All required caseworker was completed on time.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/23/2016	Sibling, Female, 9 Months	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Indicated	No
	Deceased Child, Male, 11 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 8 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 9 Months	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Indicated	

Report Summary:
On 1/23/15 at 1:50AM, there was a verbal altercation between BM and BF2 that escalated into a physical altercation while SC, SS1, SS2, SS3, and SS4 were home. BF2 hit BM multiple times, and as a result, BM sustained bruising under the left eye and possible broken ribs on the left side. The CHN were not physically harmed. The role of BM was unknown.

Determination: Indicated | **Date of Determination:** 03/16/2016

Basis for Determination:
BF2 was arrested and charged with endangering the welfare of a child, unlawful imprisonment 2nd, attempted assault, and harassment. There was an OP obtained for BM and all of the CHN. BM admitted that BF2 hit her in front of the children and that SS3 and SS4 were crying during the event. BF2 admitted to having a physical altercation with BM. BM stated that SS2 hid under the covers after seeing her get hit. SC observed BM crying and barely able to walk. SC and SS1 were afraid of BF2 and did not want him to return to their home. SS1 had disclosed to her BF that BF2 had been "beating up" BM. BF2 remained in jail at the time of case closing.

OCFS Review Results:
OCDSS did a complete and thorough investigation as they spoke to appropriate collaterals, interviewed all parties,

reviewed CPS and criminal history, offered the family DV services, preventive services, daycare services, and verified appropriate placement for the children while BM was in the hospital recovering. Safety assessments were adequate and completed on time. In the conclusion narrative, CW stated all information was compared with the statutory and regulatory standards for the purpose of rendering a decision. This is recognized as good case practice.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/07/2015	Sibling, Male, 4 Years	Mother's Partner, Male, 29 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Female, 7 Years	Mother's Partner, Male, 29 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 10 Years	Mother's Partner, Male, 29 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
On an ongoing basis, parent sub (BF2), was hitting and pushing BM while SC, SS1, and SS2 were home. Recently, police were called to the home as a result of the violence. The role of BF is unknown.

OCFS Review Results:
CHN described an incident where BM & BF2 were in their bedroom and the CHN heard something hitting the wall, and could hear yelling and BM crying. SS1 saw her mother with a mark around her eye. CW never asked the CHN about this incident. The SCR report states there was a video of the CHN discussing how BF2 hits their BM. The record does not reflect that CW ever inquired about this video. An adequate assessment of safety was not completed. OC1's mother was not notified of this report. Diligent efforts were not made to contact this mother.

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

Issue:
FAR-Failure to Address Reported or Identified Concerns

Summary:
There were serious concerns stated in the SCR intake that were not addressed. There was a video of the CHN discussing how BF2 hits their mother. SS1 also described an incident of DV. The record does not reflect that these concerns were ever addressed.

Legal Reference:
18 NYCRR 432.13 (a)(3)(iii)

Action:
OCDSS will engage the family in an assessment of the concerns reported to the State Central Register.

Issue:
FAR-Failure to Provide Notice of Report

Summary:
The record does not reflect that a mother of a subject child was provided the required written notice of existence of the SCR report.

Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:
OCDSS will provide written notification to parents. No later than seven days after receipt of a child protective report that the report has been assigned to the family assessment response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

[redacted]

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

8/7/07-1/14/08 UNF-allegations of IG & PD/AM against BM for SC
7/18/13-8/8/13 IND-allegation of IG against BM & BF2 for IG SS5, and L/B/W against BF2 for SS5
4/12/13-7/30/13 FAR-allegation of IG against BM & BF2 for alleged marijuana use in the presence of SC, SS1 & SS2.
6/12/13-7/30/13 FAR-IG. BM & BF2 for deplorable home conditions and BF2 hitting the CHN (SC, SS1, SS2, & OC1) and leaving marks on their faces.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 04/03/2017

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Required Action(s)

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

Issue:	Mandated reporters did not report potential abuse or maltreatment of a child

Summary:	On 3/6/17, OCDSS was notified that BM was a victim of DV and attempted suicide a few weeks ago. School attendance was erratic for all CHN and BM would keep CHN home to assist with younger siblings.
Legal Reference:	SSL 413 and 415
Action:	Mandated reporters must make a report of suspected abuse/maltreatment to the SCR for a complete CPS investigation. These concerns were incorrectly coded to an FSS-OTI case.
Issue:	Mandated reporters did not report potential abuse or maltreatment of a child
Summary:	OCDSS was notified of concerns BM was not keeping her twins fed and clean and therefore they were sick all of the time. Also, BM was selling her food stamps in exchange for prescription drugs. There was reasonable cause to suspect maltreatment and a report should have been made to the SCR.
Legal Reference:	SSL 413 and 415
Action:	Mandated reporters must make a report of suspected abuse/maltreatment to the SCR for a complete CPS investigation. These concerns were incorrectly coded to an FSS-OTI case.

Preventive Services History

3/7/17-3/31/17 a stand alone preventive case opened with the family with initial concerns that BM was suicidal and the CHN weren't attending school regularly. BM denied she was suicidal but reported being under a lot of stress as the family was low on food and she was worried that the father of her youngest 2 CHN would be released from jail soon. BM suffered severe physical abuse by that father. BM had schedule conflicts with her therapist and had not been able to get in. CW closed their case on 3/31/17 and a CPS report was taken the same day. The next preventive case was opened due to this CPS case being IND.

4/3/17 a preventive services case was opened for BM, SC, and SS1-4 as a result of a case that was IND against BM for drug use. BM was on probation and was arrested for drug possession. Case met all regulatory requirements and appropriate services were provided to the family. SC died during this open preventive case. Case remains open for continued monitoring.

Foster Care Placement History

There is no record of foster care placement 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 disagree that an adequate safety assessment was not completed from the 1/15 report. Our DV advocate was referred to the mother on 1/7/15. All police records are on file, FAR tools used with the children are on file and there were no bruises on mom as reported. The caseworker noted that all family members denied domestic violence. We also take exception to the miscoding in Connections regarding our NON-CPS, intake program. This was OCFS directed and practice for many years.*

Also, regarding the mandated reporter citation, the mandated reporter from the school who made the referral to NHS (Intake) either did not feel the concerns rose to a high enough level to report to the SCR or the SCR refused the report. We are not privy to that information. DSS workers will always make a required CPS report when in their official capacity they have "reasonable cause to suspect that a child is an abused or maltreated child, or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian, custodian or other person legally responsible for such child comes before them in their professional or official capacity and states from personal knowledge facts, conditions, suspicion that the information presented to them could be true. This was not the case at the time of the intake referral. An assessment was being attempted to gather more information and a report was called in when the mother was not cooperative and the voluntary Intake case was closing.

Finally, regarding the recommendation to reconsider using a FAR approach when there is potential domestic violence. OCFS has permitted local districts to decide whether DV reports can be tracked FAR. However, as a result of this fatality review, we are being asked to reconsider our practice. We are therefore, respectfully requesting written guidelines from OCFS regarding the FAR practice in potential DV cases.

*This conflicts with OCFS policy and OCDSS provided no documentation of such direction provided by OCFS.

Recommended Action(s)

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

Action:	An SCR report from 1/23/16 with allegations of DV was immediately tracked to FAR. Interviews were done while all family members were in the home. OCDSS may want to reconsider this approach because if there is DV going on, members of the home may be afraid to speak in front of others about what is going on. This DV report was taken in January 2015, and in January 2016, BF2 (the alleged subject in the January 2015 case) physically assaulted BM. BM sustained very serious injuries which placed her in the Intensive Care Unit at the hospital for several days. BM had a lengthy recovery at home upon discharge. BF2 was convicted of assaulting BM and served time in jail.

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