Child Fatality Report

Report Identification Number: SY-18-004

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

Issue Date: Jul 12, 2018

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: 7 month(s)
Jurisdiction: Oneida
Gender: Female
Date of Death: 01/21/2018
Initial Date OCFS Notified: 01/21/2018

Presenting Information

On 1/21/18, an SCR report was received by Oneida County Department of Social Services (OCDSS) about the death of the 7-month-old SC. On 1/20/18, the SC sustained a skull facture and a subdural hematoma while in the care of the parent substitute. The SC was brought to a medical facility to be treated for her injuries. The SC had difficulty breathing and was intubated. The SC was rushed into surgery but ultimately succumbed to her injuries. On 1/21/18, at 12:05AM, the SC passed away. The PS's explanation for the SC's injuries were suspicious. The SM, the BF and the 1yo SS had unknown roles.

Executive Summary

This report concerns the death of the 7-month-old female SC. OCDSS received an SCR report regarding the SC's death on 1/21/18. The SC was an otherwise healthy child and her death was suspicious. OCDSS had 2 prior SCR reports on 1/20/18 about the injuries sustained by the SC and these injuries subsequently resulted in the SC's death. OCDSS had an open CPS investigation, this investigation had been open for six months prior to the death of the SC. The allegations in the open investigation were about the SM and the BF's care of the 1yo SS and the SC, and were unrelated to the fatality. the allegations in the open investigation were unsafe living conditions, the SM had untreated mental health issues and on going domestic violence in the home. The SM had been assaulted by the BF. The BF was in prison at the time of the fatality for violating his parole after he assaulted the SM.

The SM told OCDSS that she left the SC in the care of the PS on 1/20/18, while she went to the store. The PS told LE and OCDSS that he had bumped the SC's head against the door frame. The PS' explanation was not consistent with the seriousness of the SC's injuries. The SC sustained bleeding to her brain and subsequently passed away from her injuries on 1/21/18, at 12:05AM.

The ME performed an autopsy and the final autopsy report noted manner of death was homicide.

LE jointly investigated the fatality with OCDSS. OCDSS interviewed the SM and the PS about the events leading up to the SC's death. The PS was arrested and indicted for second degree murder. The PS plead guilty to manslaughter in the first degree and was awaiting sentencing at the time of the writing of this report.

OCDSS promptly observed and assessed the safety of the 1yo SS. The 1yo SS was in the care of the MGGM at the time of the incident on 1/20/18. The SM consented to the SS being placed in the MGGM's care. OCDSS subsequently filed an Article 10 abuse/neglect petition and the court placed the SS in the MGGM's care. The SM had on going untreated mental health issues, unstable housing and was unable to care for the SS. OCDSS planned for the BF of the SS to be interviewed in prison. The BF agreed to the SS being placed with the to the MGGM.

OCDSS interviewed all collateral contacts, including but not limited to, family members, first responders, LE, and medical professionals. OCDSS obtained and reviewed all medical records pertaining to the SC's death. The safety assessments and fatality reports were completed timely and accurately.

OCDSS offered information regarding burial assistance and bereavement and grief counseling/services. OCDSS continued to engage the SM in all appropriate services to assist her in the return of the SS to her care.

The investigation remained open at the time of this writing; therefore, a determination of the allegations had not been made.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
OCDSS continued to gather information and provided appropriate services as needed.

Was the decision to close the case appropriate? N/A

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 Investigation remained open at the time of the writing of this report.

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: 01/21/2018 **Time of Death:** 12:05 AM

Child Fatality Report

Date of fatal incident, if different than date of death: 01/20/2018
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Oneida
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used 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
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Unknown if they were 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	7 Month(s)
Deceased Child's Household	Mother	No Role	Female	23 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	20 Year(s)
Deceased Child's Household	Sibling	No Role	Female	22 Month(s)

LDSS Response

On 1/21/18, OCDSS received an SCR report concerning the SC's death. OCDSS had received a report on 1/20/18 about the injuries sustained by the SC prior to the SC's passing. OCDSS initiated their investigation by contacting LE, ME and verifying the DA had been contacted. OCDSS checked the CPS history and discovered there were open CPS investigations involving the family, with allegations unrelated to the fatality.

The 1yo SS was at the home of the MGGM at the time of the reported incident. Within 24 hours of receiving the report OCDSS went to the MGGM's home to observe the SS. OCDSS made a safety plan with the family for the MGGM to care the SS. OCDSS observed the MGGM had all the appropriate provisions for the SS. OCDSS met with the SM and she signed consent for the placement of the SS with the MGGM. OCDSS offered the SM referrals for mental health services, bereavement services and assistance with burial costs. The SM was questioned about drug/alcohol use and the SM denied the misuse of drugs or alcohol.

The MGGM told OCDSS she had picked up the 1yo SS on 1/20/18 at about 4:00PM, to spend the night at her home. The MGGM told OCDSS that she often takes both Chn to spend the night but had not been feeling well and did not feel she had the energy to care for both Chn. The MGGM said did not see anything unusual at the time she picked up the SS. The

MGGM had concerns about the SM's care of the Chn.

OCDSS observed the interview of the SM by LE, about the events leading up to the SC's death. The SM denied that the PS had ever been physical with her or the chn. The SM said that the PS was a "good guy" and she never had any reason to believe he would harm the Chn. The SM said the PS in moved in with her and the Chn in Nov. of 2017. The SM said she left the home about 5:30PM to go to the store. She said the SC was crying before she left the home and she asked the PS if he was okay to watch the SC; he said that he was. The SM said she was only at the store for abut 15 minutes. The SM produced a receipt from the store with the time stamp of 5:47PM. When she arrived home, the PS told her to come upstairs. The SM said the PS called 911 at 5:54PM. The SM observed the SC on the bed, she was not breathing normally. The SM said the SC's eyes were rolling in her head. The ambulance arrived shortly after she arrived home and took the SC to the hospital. LE told OCDSS that the PS had admitted to injuring the SC.

OCDSS learned from LE that the PS was arrested for murder in the second degree. OCDSS interviewed the PS at the jail. The PS told OCDSS that he was caring for the SC while the SM went to the store. He said he accidentally bumped the SC's head against the doorframe in the bedroom while caring for her. The PS said he had been in a relationship with the SM for 4 to 6 months. The PS told OCDSS that the SM would often get physical with him during arguments and had made statements to him about not wanting the Chn or wanting them to die. He denied ever seeing the SM become physical with the Chn.

OCDSS arranged for the SS to have a full medical exam, which was completed on 1/23 and 1/24/18 at the CAC. The exams were normal and there were no concerns noted.

OCDSS arranged for the BF to be interviewed in prison. The BF had never met the PS but knew who he was. The BF agreed to the MGGM caring for the SS.

OCDSS filed an Article 10 Abuse/Neglect petition and the initial appearance was on 1/25/18. The SS was placed in a kinship custody with the MGGM. The MGGM on 2/28/18, requested the SS no longer remain in her care. OCDSS placed the SS in care pending a modification petition being filed in Family Court. The petition was filed on 3/13/18 and the SS remained in foster care. The MGM applied for custody of the SS and custody was granted on 3/28/18.

The PS plead guilty to 1st degree manslaughter and was awaiting sentencing. OCDSS continued to try and engage the SM in services, the case remained open at the time of the writing of this report

Official Manner and Cause of Death

Official Manner: Homicide
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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

046753 - Deceased Child, Female, 7 Mons	046755 - Mother's Partner, Male, 20 Year(s)	DOA / Fatality	Pending
046753 - Deceased Child, Female, 7 Mons	046755 - Mother's Partner, Male, 20 Year(s)	Inadequate Guardianship	Pending

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	☒	☐	☐	☐

Explain:
The SM was referred for Mental Health services. The SM's compliance was sporadic. At times during the investigation she had started the process for services but failed to follow through. OCDSS was continuing to try and engage the SM.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The SS was removed on 1/21/2018, the SM consented to the removal. OCDSS filed an Article 10 Abuse and Neglect Petition in Family Court and an initial appearance was held on 1/25/2018. The Judge granted removal and the SS was placed through Kinship Foster Care with the MGGM.

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:
01/24/2018	There was not a fact finding	There was not a disposition
Respondent:	046755 Mother's Partner Male 20 Year(s)	

Comments:	OCDSS filed an Abuse/Neglect Petition on 1/24/2018, the initial appearance was on 1/25/2018 and the SS was placed in Kinship Foster Care with the MGGM. On 2/28/2018, the MGGM no longer wanted the SS placed with her and the SS was moved to respite care until a modification petition could be filed. The modification was filed and heard in Family Court on 3/12/2018, the Judge ordered the SS into a Foster Home. The MGM was already granted weekend visitations and asked for the SS to be placed in her care. On 3/28/18, the Judge placed the SS with the MGM who resided in Albany County. The MGM was supervising visitation of the SS with the SM in her home.

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
01/24/2018	There was not a fact finding	There was not a disposition
Respondent:	046754 Mother Female 23 Year(s)	
Comments:	OCDSS filed an Abuse/Neglect Petition on 1/24/2018, the initial appearance was on 1/25/2018 and the SS was placed in Kinship Foster Care with the MGGM. The SM was unable to provide stable and safe housing for the SS. The SM had untreated mental health issues which impaired her ability to provide a minimum degree of care for the SS.	

Criminal Charge: Manslaughter **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	mother's partner	Pending	Manslaughter 1st
Comments:	The Parent Substitute plead guilty to Manslaughter in the 1st degree on 5/9/2018 and it was documented he was to be sentenced for 20 years. Sentencing was due to take place on 6/26/2018.		

Have any Orders of Protection been issued? Yes	
From: 01/24/2018	**To:** Unknown
Explain: As a result of the abuse petition there was a Family Court Order of Protection issued by the Court for the SS. This temporary order of protection remained in place.	

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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: The SS had a full exam and evaluation at the CAC. The exam was negative for any injuries.							

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:
OCDSS removed the SS and the SS had full exam and evaluation at the CAC. The exam was negative for any injuries.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS offered all family members referrals for bereavement and offered the SM assistance with burial costs. OCDSS referred the SM for Mental Health services.

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? 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

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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)
01/20/2018	Deceased Child, Female, 7 Months	Mother's Partner, Male, 20 Years	Fractures	Pending	No
	Deceased Child, Female, 7 Months	Mother's Partner, Male, 20 Years	Internal Injuries	Pending	
	Deceased Child, Female, 7 Months	Mother's Partner, Male, 20 Years	Inadequate Guardianship	Pending	

Report Summary:
On 1/20/2018, OCDSS received 2 reports about the SC sustaining a skull fractures and subdural hematomas. The SC was in the care of the PS when the injuries occurred. The role of the SM was unknown.

Report Determination: Undetermined

OCFS Review Results:
After OCFS review, it was determined OCDSS conducted a thorough investigation, however the record contains no determination.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/19/2017	Sibling, Female, 1 Years	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 4 Months	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 1 Years	Father, Male, 31 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 4 Months	Father, Male, 31 Years	Inadequate Guardianship	Substantiated	

Report Summary:
Oneida County Family Court ordered a COI on 10/19/17 for on going custody matters. Report had a return date of 11/14/17.

Report Determination: Indicated **Date of Determination:** 05/10/2018

Basis for Determination:
OCDSS determined there was some credible evidence to support the allegation of IG against both parents for the chn. Throughout the INV, the home was observed to be cluttered and dirty, to the point where the parents had been advised to clean it up. There was history of the BF assaulting the SM in the presence of the Chn. The BF was arrested on a violation of parole as a result of the assault and was sent back to prison. The SM had serious mental health issues and failed to engage in treatment, despite being advised to do so. The SM did not maintain stable housing. While this INV remained open, a new report was received about the death of the SC. The case was opened for mandated CPS services.

OCFS Review Results:
The source was contacted. There was no documentation in the case record that a history check was completed. The notice of existence letters were not sent within the required time frame. The subjects and other adults named were interviewed face to face and the children seen. All allegations that arose were discussed and notes were documented contemporaneously in the record up until 11/8/2017. From 11/8/2017 until 1/20/18 the case remained open with no contact made by OCDSS. On 1/20/18 a report was received about the SC being left alone with the PS and the SC sustained multiple injuries resulting in the reported death of the SC on 1/21/18.

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

Issue:
Review of CPS History
Summary:
The SCR report was received on 10/19/17 and the CPS history was not documented that it was completed until 10/26/17. The documentation was listed in the 7 day safety assessment.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, OCDSS 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:
Failure to provide notice of report
Summary:
OCDSS had not provided the notice of report until 5/10/18. This was 6 months after the report was received.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will provide notice of report within the required time frames.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/02/2017	Sibling, Female, 1 Years	Father, Male, 31 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 1 Years	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Deceased Child, Female, 2 Months	Father, Male, 31 Years	Inadequate Guardianship	Substantiated	

Deceased Child, Female, 2 Months	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 1 Years	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 1 Years	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 1 Years	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Substantiated
Deceased Child, Female, 2 Months	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 2 Months	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Substantiated
Deceased Child, Female, 2 Months	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Substantiated

Report Summary:
On 8/2/17, OCDSS received an SCR report. Subsequently, 3 additional reports were received and consolidated. The reports alleged unsafe home conditions, SM's untreated mental health issues which impaired her ability to care for the Chn. The SM was using drugs/alcohol to the point she was unable to care for the Chn. There were concerns about the BF assaulting the SM in the presence of the chn. The SM had left the Chn in the care of the BF knowing he was incapable of caring for the Chn.

Report Determination: Indicated | **Date of Determination:** 04/19/2018

Basis for Determination:
OCDSS found the home cluttered and dirty on several occasions. The SM admitted to multiple mental health issues and failed to get treatment. The BF had assaulted the SM in the presence of the Chn. OCDSS had found the BF home with the Chn and unable to care for them. OCDSS had educated the parents numerous times about safe sleep provisions. The parents failed to provide safe sleep a safe sleep environment. The parents failed to provide a minimum degree of care. The case was opened for Mandated CPS services.

OCFS Review Results:
The source was contacted. The history check was not documented as being completed within the required time frames. The notice of existence letters were sent but not within the required time frame. The subjects and other adults named were interviewed face to face and all children seen and interviewed when appropriate. All allegations that arose were discussed and notes were documented contemporaneously in the record up until 11/8/2017. From 11/8/2017 until 1/20/18 the case remained open with no contact made by OCDSS. On 1/20/18, a report was received about the SC being left alone with the PS and the SC sustained multiple injuries resulting in the reported death of the SC on 1/21/18.

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

Issue:
Review of CPS History

Summary:
The SCR report was received on 8/2/17 and the CPS history was not documented that it was completed until 8/8/17. The documentation was listed in the 7 day safety assessment.

Legal Reference:
18 NYCRR 432.2(b)(3)(i)

Action:
Within 1 business day of a report, OCDSS 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:
Failure to provide notice of report
Summary:
OCDSS had not provided the notice of report until 8/30/18. This was 21 days after the report was received.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will provide the notice of report within the required time frames.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/26/2016	Sibling, Female, 4 Months	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 4 Months	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
There were ongoing physical altercations in the home between the SM and the BF of the SS, in the presence of the infant. The SM had mental health issues and was not compliant with medication. The BF was a registered sex offender. The SM allowed him to reside in the home. The infant was dirty and had poor hygiene.

Report Determination: Unfounded | **Date of Determination:** 12/22/2018

Basis for Determination:
There was no credible evidence to support the allegation of IG against the SM and the BF of the SS. OCDSS learned through interviews with family and collateral contacts that the BF was on probation for and was a registered sex offender, his parole officer said there were no restrictions. The parents denied any domestic violence and there was only one DIR for a verbal dispute. OCDSS observed the home and the infant and there were no safety concerns. OCDSS went over safe sleep and the infant had all appropriate supplies. OCDSS had been in contact with the SS' pediatrician and there were no concerns for the care of the SS. The case was UNF and Closed.

OCFS Review Results:
The OCFS review found OCDSS had gathered sufficient information to make a determination in this investigation.

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

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

There was no history more then three prior to the fatality.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

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

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