Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-21-001

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

Issue Date: Jun 28, 2021

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 12/30/2020
Initial Date OCFS Notified: 01/04/2021

Presenting Information

A 7065 Agency Reporting Form was provided to OCFS after Oneida County Department of Family and Community Services (OCDFCS) learned of the death of the child during an open CPS investigation regarding the child's absences from school and counseling. During the investigation, the child and father began living with the aunt in Madison County. Madison County Department of Social Services (MCDSS) opened a Family Services Intake on 12/24/2020 as the child was displaying behavioral concerns. The child died after being struck by a car while walking on a dark roadway.

Executive Summary

This fatality report concerns the death of the 16-year-old male subject child that occurred on 12/30/2020. The child died during an open CPS investigation being conducted by Oneida County regarding concerns the father was not providing the child with his prescribed medications, the child did not attend school and was missing counseling sessions. Additionally, Madison County Department of Social Services (MCDSS) was in the process of opening a Preventive Services Case to assist the father in controlling the child's behavior. At the time of his death, the child and father were temporarily residing at the aunt's home in Madison County. There were three surviving siblings, ages 4, 8, and 13 who were assessed to be safe with their mothers.

On 12/31/2020, Oneida County Department of Family and Community Services (OCDFCS) completed the 7065 Agency Reporting Form, notifying OCFS of the death. It was learned that the child was struck and killed by a car while he was walking on a dark roadway.

OCDFCS gathered information regarding the death from law enforcement and determined the death was not a result of neglect or maltreatment. Law enforcement planned to close their investigation without charges. The medical examiner listed the preliminary cause of death as multiple blunt trauma due to motor vehicle collision (pedestrian).

Family members were interviewed, and it was learned the child snuck out of the home on 12/27/2020 and was reported missing on 12/29/2020. The family members did not have information regarding the death as the child was unsupervised when he was struck by the car. The family did not have concerns for the safety of the child or the siblings.

OCDFCS offered the father bereavement services. It remained unknown if the father enrolled in counseling as he was not certain whether he would engage in the services or not. Although the parents of the siblings were provided with grief counseling referrals, it remained unknown if the family utilized the services. The case was closed after all requirements were met.

PIP Requirement
Regarding historical cases, Madison County DSS (MCDSS) and OCDFCS will submit a PIPs to the Syracuse Regional Office within 30 days of the receipt of this report. The PIPs will identify action(s) the counties has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, the counties will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
A Safety Assessment was not required as the death was not reported to the SCR and therefore, no determination needed to be made.

Was the decision to close the case appropriate? Yes

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

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

Explain:
The record included supervisory consultations.

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: 12/30/2020 **Time of Death:** 06:22 AM

Time of fatal incident, if different than time of death: 06:00 AM

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? Unknown
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown

☒ Other: Walking on roadway

Did child have supervision at time of incident leading to death? No - but needed
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted
☐ Asleep
☒ Absent
☐ Other:

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	Aunt/Uncle	No Role	Female	36 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	16 Year(s)
Deceased Child's Household	Father	No Role	Male	35 Year(s)
Other Household 1	Other Adult - Mother of older siblings (OA)	No Role	Female	34 Year(s)
Other Household 1	Sibling	No Role	Male	13 Year(s)
Other Household 1	Sibling	No Role	Female	9 Year(s)
Other Household 2	Other Adult - Mother of 4-year-old sibling (OA2)	No Role	Female	34 Year(s)
Other Household 2	Sibling	No Role	Male	4 Year(s)
Other Household 3	Mother	No Role	Female	42 Year(s)

LDSS Response

OCDFCS learned of the death on 12/30/20 and provided OCFS with the required reporting form timely. The safety of the surviving siblings was assessed throughout the open CPS investigation and they were deemed safe in the care of their mothers.

LE provided information regarding the fatal incident and death to OCDFCS. The aunt filed a missing person's report regarding the child the day before the child was struck and killed. Police said family members identified the child's body and the officer said the driver was traumatized; therefore, law enforcement was not forthcoming with information regarding the driver. Law enforcement planned to close their case as they did not find criminality and believed the death was an accident. Additionally, law enforcement said the driver did not see the child walking in the road until it was too late, and the driver was unable to stop in time. At the time of the accident, the roadway was dark and unlit, and the child was dressed in black clothing. It was learned the driver immediately called 911 and performed CPR until EMS arrived. EMS responded and the child was pronounced deceased at the scene by a paramedic. There was no evidence to support the driver was distracted or impaired when the child was struck around 6:00 AM. Law enforcement confirmed the aunt reported the child was missing prior to his death after he snuck out of the home through the bathroom window. Law enforcement reported the child had run away four times within the month leading up to his death and a missing person report was filed each time.

The father was interviewed with the mother of the younger siblings. Prior to the child running away, the aunt left a note for the child telling him to do the dishes and his homework and she left the home. When she returned, the child had gone into

the bathroom and left out of the window. The aunt did not have additional information. The mothers of the siblings did not have concerns for the care of the child or the siblings. Additionally, the siblings were assessed and there were no concerns for their safety. OCDFCS made attempts to speak with the mother of the subject child; however, she ended the call without discussing the case. The mother did not have a relationship with the child.

The medical examiner's report stated the child was walking along a rural roadway in the morning hours of 12/30/20 when he was struck by a motor vehicle, was thrown into a ditch, and was wedged into a culvert pipe. The child had a severe open head injury. The preliminary autopsy report noted the vehicle was traveling at approximately 65 miles per hour and the roadway had a trace amount of ice on the shoulders.

OCDFCS completed all required casework and offered the family services in response to the fatality. The preventive case and the investigation were closed following the death as the family was not in need of further assistance from OCDFCS or MCDSS.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The death was referred to the Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
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 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 father was offered bereavement services but was undecided if he wanted to participate. No Risk Assessment Profile was required.				

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: The children did not need to be removed.				

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	☐	☐	☐	☐	☐	☒	☐

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? Unable to Determine
Explain:
Although provided with referrals, it remained unknown if the siblings were engaged in services in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The father was offered bereavement services in response to the death.

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? Yes
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/17/2020	Deceased Child, Male, 16 Years	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 16 Years	Father, Male, 35 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 16 Years	Father, Male, 35 Years	Lack of Supervision	Substantiated	

Report Summary:
An SCR report alleged the 16-year-old subject child was diagnosed with mental health conditions and was prescribed medications. The father did not follow through and provide the child with the necessary medications. The child did not attend school in the 2020-2021 school year and missed counseling provided by the school.

Report Determination: Indicated **Date of Determination:** 03/19/2021

Basis for Determination:
The allegations of Inadequate Guardianship, Lack of Supervision and Lack of Medical Care were substantiated against the father with regard to the child. The father did not provide a stable home for the child nor were the child's educational or mental health needs met. The child was "couch-surfing." The father was unable to meet the child's needs and allowed the child to fend for himself. The child died after being struck by a car during the investigation.

OCFS Review Results:
The investigation was initiated timely by contacting the source. A CPS history check was completed. Written notice of the SCR report was not provided timely to the father or to the aunt who the child was residing with. Interviews were conducted with the family and relevant collateral contacts. The death was adequately investigated. The 7-day Safety Assessment was completed timely and accurately.

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

Issue:
Failure to provide notice of report

Summary:
The father was provided with written notice of the SCR report untimely on 12/30/2020. Although the child was residing with his aunt, the record did not reflect the aunt was provided with written notice of the SCR report.

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

Action:
OCDFCS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/29/2019	Deceased Child, Male, 15 Years	Father, Male, 34 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Male, 15 Years	Father, Male, 34 Years	Lack of Supervision	Far-Closed	

Report Summary:
MCDSS received an SCR report that alleged the 15-year-old subject child was not registered for school and was failing as a result. The father was aware but failed to adequately address the situation. The child had behavioral problems, ran away from home for weeks at a time and engaged in illegal activities. The father did not provide adequate supervision for the child.

OCFS Review Results:
The investigation was initiated timely and assigned to FAR. The source of the report was contacted, and a CPS history check was completed. The 7-day Safety Assessment was completed untimely. The FLAG was completed with the father and child. The record did not reflect attempts to contact the mother or notify her of the SCR report in writing. Progress notes were not entered contemporaneously to their event dates. The child's safety was not assessed for approximately 2 months prior to case closure.

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

Issue:
FAR-Insufficient Number of Casework Contacts
Summary:
The record did not reflect the child's safety was assessed between 11/6/19 and 2/5/20 when the investigation was closed.
Legal Reference:
18 NYCRR 432.13 (e)(4); 18 NYCRR 432.13 (e)(3)(v)(d)(2)
Action:
MCDSS will prioritize making an adequate assessment of safety and risk to all children in the household and continue an on-going assessment of safety and risk throughout the length of the case. A Family Assessment Response worker must make contact with the family no less than once every two weeks during the period past 90 days, and must document each contact.

Issue:
FAR-Failure to Provide Notice of Report
Summary:
The record did not reflect the mother was provided with written notice of the SCR report.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
MCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available and document attempts to obtain contact information.

Issue:
FAR-Timely/Adequate 7-Day Assessment
Summary:
The 7-day Safety Assessment was completed untimely on 11/15/19.
Legal Reference:
18 NYCRR 432.13 (d)(2)(i) and (ii); 18 NYCRR 432.13(d)(3)
Action:

MCDSS will complete all Safety Assessments in the accordance with regulations.

Issue:
FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible
Summary:
The record did not reflect attempts to interview the mother regarding the SCR report.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)
Action:
MCDSS will contact or make diligent efforts to contact relevant collateral sources who may have information relevant to the investigation, including absent parents.

Issue:
FAR-Timely/Adequate Documentation
Summary:
Some progress notes were not entered contemporaneously to their event dates. Progress notes were entered more than 2 months after their event dates.
Legal Reference:
18 NYCRR 432.13 (e)(5)
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/28/2019	Deceased Child, Male, 15 Years	Other Adult - OA2, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 15 Years	Other Adult - OA2, Female, 33 Years	Sexual Abuse	Unsubstantiated	
	Deceased Child, Male, 15 Years	Father, Male, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 15 Years	Father, Male, 34 Years	Sexual Abuse	Unsubstantiated	

Report Summary:
An SCR report received by MCDSS alleged the father and OA2, the mother of the youngest sibling, were evicted from their home with the child, and OA2's children, ages 2 and 6 years. The adults made plans for the child to stay with a relative. The relative did not provide adequate care for the child and let him leave her home for days at a time to be at his girlfriend's home. The child slept at his girlfriend's home and engaged in sexual activity. The OA2 and father were aware the relative was not adequately caring for the child but did not intervene. As a result, the child stayed at his girlfriend's house and was sexually active.

Report Determination: Unfounded | **Date of Determination:** 05/15/2019

Basis for Determination:
The allegations of Inadequate Guardianship and Sex Abuse were unsubstantiated against OA2 and her partner regarding the child. The investigation did not reveal credible evidence to support the allegations as the family denied the child did not have a place to stay or that he was sexually active.

OCFS Review Results:
The investigation was initiated timely and the source of the report was contacted. Progress notes were entered timely.

The 7-day Safety Assessment was completed timely and accurately. The history check was completed untimely. Interviews were conducted with the children and collateral contacts. Written notice letters were not provided to all parents and all parents were not contacted. The unrelated adult was documented as "reported in error;" however, the record did not include a basis for the reasoning. The record did not reflect an MDT approach was used or that law enforcement was notified of the allegations. The record does not reflect the family was referred to the CAC.

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

Issue:
Review of CPS History
Summary:
A history check was completed untimely on 4/11/19.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, MCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, MCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
The record did not reflect attempts to interview the father of OA2's oldest child or the mother of the subject child.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
MCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available and MCDSS will make diligent attempts to obtain contact information.

Issue:
Failure to provide notice of report
Summary:
The record did not reflect notice of existence letters were provided to the unrelated adult or the father of OA2's oldest child.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
MCDSS will contact or make diligent efforts to contact relevant collateral sources who may have information relevant to the investigation, including absent parents.

Issue:
Failure to utilize an approved MDT
Summary:
The record did not reflect law enforcement was called or that a multi-disciplinary approach was used to complete the investigation despite the abuse allegations. The record did not reflect the district attorney was notified of the report.
Legal Reference:
SSL 423(6); SSL 424 (5-a); 10-OCFS-LCM-09
Action:
SCR reports including abuse allegations must be investigated by a multi-disciplinary team (MDT). Members of an MDT must include, but are not limited to: CPS; law enforcement; the district attorney's office; a physician or medical provider

trained in forensic pediatrics; mental health professionals; victim advocacy personnel; and, if one exists, a child advocacy center.

Issue:
Failure to notify Law Enforcement of an SCR report alleging Sex Abuse

Summary:
The record did not reflect law enforcement was contacted regarding the sex abuse allegations.

Legal Reference:
SSL 424(5-a)

Action:
CPS must provide telephone notice and immediately forward copies of reports to the appropriate local law enforcement entity if the report alleges: the death of a child, sexual abuse of a child, or physical abuse of a child.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/02/2018	Deceased Child, Male, 14 Years	Other Adult - OA2, Female, 32 Years	Excessive Corporal Punishment	Unsubstantiated	Yes
	Deceased Child, Male, 14 Years	Other Adult - OA2, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 14 Years	Other Adult - OA2, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 14 Years	Other Adult - Father of 5-year-old OC, Male, 33 Years	Excessive Corporal Punishment	Unsubstantiated	
	Deceased Child, Male, 14 Years	Other Adult - Father of 5-year-old OC, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 14 Years	Other Adult - Father of 5-year-old OC, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 14 Years	Other Adult - Father of 5-year-old OC, Male, 33 Years	Fractures	Unsubstantiated	

Report Summary:
An SCR report alleged OA2 and her partner hit and slapped the 15-year-old child on his head as punishment. The partner pulled the child's hair and punched the child in the left eye for unknown reasons causing the child to sustain a broken orbital bone. OA2 and the partner did not ensure that the child had adequate food and as a result he missed meals and was hungry. The child did not have appropriate fitting clothes or shoes. The child was fearful of the adults.

Report Determination: Unfounded | **Date of Determination:** 11/05/2018

Basis for Determination:
The Investigation Conclusion Narrative stated OA2 was unsubstantiated for XCP, IG, FX, IF/C/S regarding the child. Her partner was unsubstantiated for XCP, IF/C/S and IG regarding the child; however, these allegations did not match the reported allegations for the subjects. The investigation revealed the child had access to ample amounts of food and was not excessively physically disciplined by the adults. Furthermore, the child had adequate clothing. The injury to the child was previously investigated and revealed the child lied about the injury to avoid getting in trouble.

OCFS Review Results:
The investigation was initiated timely and the subjects and children were interviewed and observed. Home visits were made, and the homes were assessed. Collateral contacts were made. A CPS history check was documented untimely. The 7-day Safety Assessment was completed late. The Safety Assessments did not reflect case circumstances. The Risk Assessment Profile was completed inaccurately. Written notice of the SCR report was provided timely. The record did not note attempts to interview the mother.

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

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
The Safety Assessments did not accurately reflect case circumstances with regard to safety. The safety factor regarding the BF's inability to care for the SC was selected and referenced an event from 2010. Safety factors involving drugs and alcohol were chosen yet the record did not note a negative impact on the CHN. The safety factor regarding MH was chosen yet noted OA2's MH was well-managed.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
The results of each safety assessment must be accurately documented in the case record to reflect case circumstances with regard to safety.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day Safety Assessment was completed untimely on 10/29/18.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
MCDSS will complete all safety assessments in the amount of time required.

Issue:
Review of CPS History
Summary:
A CPS history check was documented untimely on 9/10/18.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, MCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, MCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
Although written notice of the SCR report was mailed to the mother, the record did not reflect attempts to interview the mother.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
MCDSS will make efforts to make casework contacts with biological parents and/or persons named in a report.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The Risk Assessment Profile was not all inclusive of case circumstances. The record reflected the child was in Foster Care in another state prior to the SCR report; however, this was not reflected in the Risk Assessment Profile.

Additionally, the risk factor regarding drug use was selected yet the record did not reflect the father's drug use negatively affected the children.

Legal Reference:

18 NYCRR 432.2(d)

Action:

MCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile. MCDSS will complete Risk Assessment Profiles that fully reflect case circumstances

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/16/2018	Deceased Child, Male, 14 Years	Father, Male, 33 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Male, 14 Years	Father, Male, 33 Years	Lacerations / Bruises / Welts	Far-Closed	

Report Summary:

An SCR report alleged in November 2017, the father was angry and punched the child in the face causing the child to sustain a black eye.

OCFS Review Results:

The case was appropriately tracked FAR and the source of the report was contacted. The family was engaged together, and the FLAG was completed. A CPS history check was completed untimely. The home was assessed, and collateral contacts were made. There was not an ongoing assessment of safety and risk for the children. The record did not reflect attempts to contact all biological parents. The 7-day Safety Assessment was completed untimely and inaccurately. Not all parents were provided with written notice of the SCR report. Services were offered to the family.

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

Issue:

Review of CPS History

Summary:

A CPS history check was documented untimely on 6/25/18.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

Within 1 business day of a report, MCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, MCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:

FAR-Timely/Adequate 7-Day Assessment

Summary:

The 7-day Safety Assessment was completed untimely on 6/6/18 and was completed regarding risk, not current safety concerns. The safety factors regarding drug use and mental health were selected; however, the record did not note drug use or the mental health status of OA2 had a negative impact on supervising, caring for or protecting the children.

Legal Reference:

18 NYCRR 432.13 (d)(2)(i) and (ii); 18 NYCRR 432.13(d)(3)

Action:

The results of each safety assessment must be accurately documented in the case record to reflect case circumstances with regard to safety. MCDSS will complete all safety assessments in the amount of time required.

Issue:
FAR-Failure to Provide Notice of Report
Summary:
Although some adults were provided with written notice of the SCR report, the record did not reflect the mother of the child or the father of the 5-year-old child were provided with written notice.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
MCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:
FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible
Summary:
The record did not reflect attempts to interview or gather information from biological parents except for OA2 and the father.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)
Action:
MCDSS will make efforts to make casework contacts with biological parents and/or persons named in a report.

[redacted]

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

1/13/10- 2/21/10 The BF was Sub for IG, L/B/W and IINJ of SC. The OA was UnSub for IG.

1/30/11- 3/29/11 The OA was UnSub for IG and XOTH of SC and SS. The BF was UnSub for XOTH of SC and UnSub for IG, PD/AM for SS and SC.

10/14/10- 12/22/10 The BF and OA were UnSub for IG and L/B/W of SC.

10/28/11- 12/30/11 The BF and OA were Sub for LMED of SC. The BF was UnSub for IG and L/B/W of SC.

4/5/13- 6/6/13 The OA was UnSub for IG of SC. The BF was UnSub for L/B/W of SC.

1/23/14- 4/8/14 The OA and BF were unsubstantiated for XOTH of they 13yo SS.

3/11/15- 4/14/15- The BF was UnSub for IG of SC and IG and L/B/W of OC. OA2 was UnSub for IG of SSs and SC.

8/17/15- 12/31/15 The BF had allegations of IG and L/B/W of SC on an case assigned to FAR.

11/3/15- 3/22/15- The OA2 and BF had allegations of IG, IF/C/S, and LMED of SC.

11/20/15- 3/22/16 The OA2 had allegations of IG, IF/C/S against SC on a case assigned to FAR.

9/15/16- 12/1/16 The grandparent had allegations of IG, LS, PD/AM regarding SC on a case assigned to FAR.

12/19/16- 2/19/17 Other unrelated adults were UnSub for IG and PD/AM against SC.

Known CPS History Outside of NYS

The record reflected the child was removed from his mother's care and placed into Foster Care in Oregon in 2009; however, the records were not obtained and no further information was known.

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: 12/24/2020

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☐	☐	☒	☐
Did the services provided meet the service needs as outlined in the case record?	☐	☐	☒	☐
Did all service providers comply with mandated reporter requirements?	☐	☐	☒	☐
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?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☐	☐	☒	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

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?	☒	☐	☐	☐

Preventive Services History

From 7/29/08 - 10/7/08 and from 8/20/09- 9/17/09, preventive cases were opened through the Interstate Compact on the Placement of Children were opened. In February 2009, the child was transferred from Foster Care in Oregon to New York to be in the care of the father. The records did not include documentation of casework activity.

A Preventive Services Case was opened from 2/11/10- 2/23/11 after Madison County filed a Neglect Petition against the father with regard to the child for excessive corporal punishment. A refrain-from order of protection was issued barring the father from using corporal punishment against the child. The family was offered and engaged in parenting classes, mental health counseling and bi-weekly casework counseling was provided inside of the home. The case was closed after the judge ordered an Adjournment in Contemplation of Dismissal. The court order expired and the case was closed.

From 12/24/20- 1/4/21 Madison County was in the process of opening a Preventive Services Case for the family in order to assist the father in controlling the child's behavior. The child died during the intake process and the case was closed thereafter.

Foster Care Placement History

It was known the child was removed from the care of his mother in the state of Oregon in 2009; however, despite efforts by OCDFCS no additional information was gathered.

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