Child Fatality Report

Report Identification Number: AL-16-015

Prepared by: Albany Regional Office

Issue Date: Jun 28, 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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 2 year(s)

Jurisdiction: Clinton
Gender: Male

Date of Death: 08/09/2016
Initial Date OCFS Notified: 08/10/2016

Presenting Information

On 8/9/16 at around 7:00pm, the mother found subject child (age 2) hanging from a piece of plywood that was screwed in to the wall. The subject child had small scratches and ligatures across his neck. The subject child was locked in a room because the birth mother could not handle him. The room had two entry ways. The one entry way had a door that was bolted shut, and the other entry way had a piece of plywood across it and was screwed in to the wall. The bottom of the plywood was cut through which the child could be fed. In the room, there was only a toddler bed, a mattress and no blankets. The subject child would climb on top of his mattress to look out of the room. He would lead his head against a u shaped notch in the plywood. Last night the subject child did this and the mattress gave way resulting in the subject child hanging himself. The injuries to the subject child's neck are consistent with the plywood notch. The other adults in the home were aware and did nothing.

Executive Summary

This fatality report concerns the death of a two-year-old male that occurred on 8/9/16. The subject child had been put in his bedroom for a nap at approximately 5:30pm. Across the entryway to the subject child's bedroom was a plywood board approximately four feet high which had been screwed in to the wall to keep the subject child contained in the bedroom. The plywood board had a notch cut out of the top just large enough for the subject child's head. At approximately 6:30pm the mother's paramour checked on the subject child and found him sleeping. The mother checked on the subject child shortly after 7:00pm and found the child hanging by his neck on the board. The mother and mother's paramour drove the subject child to the emergency room where the subject child was pronounced dead. At the time of the death, the subject child was residing with his mother, mother's paramour, maternal aunt, and maternal grandmother. While the autopsy report was not available at the conclusion of the investigation, the medical examiner reported that the cause of death was asphyxiation and the manner would likely be ruled accidental. The medical examiner shared that the notch in the plywood board matched the ligature marks on the child's neck and it did not appear the subject child's asphyxiation was from anything other than hanging. The case was opened on 8/10/16 as a result of a report made to the New York Statewide Central Register (NY SCR) alleging DOA/Fatality, Inadequate Food, Clothing, and Shelter, and Inadequate Guardianship of the subject child by the mother and mother's paramour and Inadequate Food, Clothing, and Shelter, and Inadequate Guardianship of the subject child by the maternal grandmother and maternal aunt. A duplicate report was also made to the NY SCR on 8/15/16. Clinton County DSS (CCDSS) gathered information pertaining to the subject child's death through interviews with the mother, the mother's paramour, the maternal grandmother, the maternal aunt, the birth father, extended family members, law enforcement, emergency room personnel, and the medical examiner. Throughout the investigation, CCDSS made home visits, offered grief services, offered and provided preventive services, and gathered information through criminal and probation records, medical records, and various service provider records. Criminal records produced that the mother and mother's paramour each had one previous criminal conviction for disorderly conduct. During the investigation, CCDSS found that the mother and mother's paramour would place the subject child in his room as a means of containing the subject child and the other adults in the home had knowledge without intervening. As a result, on the day of the incident, the subject child pulled his mattress to the entry of his bedroom and stood on his mattress to watch television through the notch cut out of the top of the plywood board when the mattress slipped out from under the subject child resulting in the subject child hanging himself with the weight of his body. It was further learned that the mother's paramour would feed the subject child while he was in his

room through an opening at the bottom of the plywood board prior to leaving for work as the mother was often still sleeping. CCDSS substantiated the allegations of DOA/fatality, Inadequate Food, Clothing, and Shelter, and Inadequate Guardianship of the subject child by the mother and the mother's paramour, and also substantiated the allegations of Inadequate Food, Clothing, and Shelter and Inadequate Guardianship of the subject child by the maternal grandmother and the maternal aunt. CCDSS closed their investigation on 10/10/16 and the family was opened for preventive services as the mother was pregnant with a due date the end of October 2016. The Albany Regional Office gathered information for this report from CONNECTIONS, CCDSS records, and interviews with CCDSS staff.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
While the CCDSS caseworker completed safety assessments in CONNECTIONS, no surviving sibling or other child resided in the home of which to assess safety.

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:
CCDSS caseworker completed a thorough investigation of the death of the subject child and appropriately opened the case for preventive services.

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: 08/09/2016 **Time of Death:** 08:18 PM

County where fatality incident occurred: CLINTON
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☒ Other: Watching television

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was:

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	Alleged Perpetrator	Female	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	24 Year(s)

LDSS Response

On 8/10/16 CCDSS received a fatality report and immediately contacted the source of the report and coordinated a joint investigation with LE. Since the date of the incident was 8/9/16, LE had already begun conducting interviews including interviewing the mother and the mother's paramour. At the time of the incident, the mother and the mother's paramour were residing in the home of the MGM and MA. CCDSS caseworker conducted interviews with the mother, the MGM, the MA, and extended family members on 8/10/16. Interviews were conducted with the mother's paramour and his extended family on 8/12/16. The mother and mother's paramour both admit to putting the SC in the bedroom for a nap around 5:30pm on 8/9/16. The bedroom had a plywood board screwed in to the wall across the entry way. The board had a notch cut out of the top just wide enough for the SC's head. The SC had pulled his mattress over to the board and stood on the mattress to watch television out of the notch. The mattress slid out from under the SC and the SC was hung by the weight of his body with his head stuck in the notch on the board. The mother's paramour reported he checked on the SC at 6:30pm and he was sleeping. The mother checked on the child a little after 7:00pm and found the child hanging. The mother pulled the SC over the board, laid him on the recliner, and attempted CPR. The mother and mother's paramour drove the SC to the emergency room rather than calling 911 as they believed it would be faster. While the MGM and MA were not home at the time of the incident, they both denied the allegations that the SC was often put in the room for extended periods of time. The MGM described the SC as rambunctious and shared the SC was placed in his bedroom for

time out or if they were unloading groceries from the car as the SC would run toward the road. The MGM also reported that the SC's bed was screwed to the wall as he would often move the furniture in his bedroom. Although the MGM also denied that the child was fed through a slot under the plywood across the door, the mother's paramour did admit to giving the SC food while he was in the room, prior to leaving for work as the mother was often still sleeping. LE shared information they obtained with CCDSS including photos taken of the home at the time of the incident. The photos demonstrated the condition of the home was in disarray with items including dirty diapers and garbage about the floors. On 8/15/16 a duplicate report was received regarding the death of the SC. Throughout the investigation, CCDSS conducted home visits at both the home of extended family members as well as the MGM's home. CCDSS obtained all appropriate collateral information regarding the SC's death including emergency room records, medical records, interviews with extended family, interviews with the biological father, records from LE, criminal and probation records, and an interview with the medical examiner. While the autopsy report was not finalized at the completion of the investigation, CCDSS obtained information from the medical examiner regarding the cause and manner of death. The medical examiner shared the cause was asphyxiation and the manner would likely be ruled accidental. The medical examiner explained that the plywood board matches the ligature marks on the SC's neck perfectly and it did not appear the SC was asphyxiated other than from hanging. Additionally, given the case details the medical examiner determined the child as emotionally, hygienically, and intellectually neglected. On 10/10/16 CCDSS substantiated the allegations of DOA/Fatality against the mother and mother's paramour and substantiated the allegations of IF/C/S and IG against the mother, the mother's paramour, the MGM, and the MA. CCDSS opened a case for preventive services with the mother, the mother's paramour, the MGM, and the MA as during the investigation the MA gave birth to a baby and the mother was eight months pregnant.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: While the report wasn't received until the following morning after the child's death, CPS and Law Enforcement conducted a joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
035261 - Deceased Child, Male, 2 Yrs	035262 - Mother, Female, 21 Year(s)	DOA / Fatality	Substantiated
035261 - Deceased Child, Male, 2 Yrs	035265 - Grandparent, Female, 44 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
035261 - Deceased Child, Male, 2 Yrs	035263 - Mother's Partner, Male, 24 Year(s)	DOA / Fatality	Substantiated
035261 - Deceased Child, Male,	035262 - Mother, Female, 21 Year(s)	Inadequate Food / Clothing /	Substantiated

2 Yrs		Shelter	
035261 - Deceased Child, Male, 2 Yrs	035263 - Mother's Partner, Male, 24 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
035261 - Deceased Child, Male, 2 Yrs	035262 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
035261 - Deceased Child, Male, 2 Yrs	035263 - Mother's Partner, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
035261 - Deceased Child, Male, 2 Yrs	035265 - Grandparent, Female, 44 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

Additional information:
Documentation included both CONNECTIONS record documentation and external documentation.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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:**
11/07/2016	There was not a fact finding	There was not a disposition
Respondent:	035262 Mother Female 21 Year(s)	
Comments:	The mother and mother's paramour fled to the state of New Jersey just prior to the mother giving birth to their new baby. CCDSS filed a neglect petition in Clinton County Family Court on 11/7/16 and with the assistance of New Jersey through ICPC, the baby was removed and placed in foster care on 11/14/16.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
11/07/2016	There was not a fact finding	There was not a disposition
Respondent:	035263 Mother's Partner Male 24 Year(s)	
Comments:	The mother and mother's paramour fled to the state of New Jersey just prior to the mother giving birth to their new baby. CCDSS filed a neglect petition in Clinton County Family Court on 11/7/16 and with the assistance of New Jersey through ICPC, the baby was removed and placed in foster care on 11/14/16.	

Criminal Charge: Criminally negligent homicide **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
12/16/2016	Mother's Partner	Pending	Pending
Comments:	The mother's paramour was arrested and charged with criminally negligent homicide on 12/16/16 as a result of the death of the subject child. The mother's paramour remains incarcerated at this time.		

Criminal Charge: Criminally negligent homicide **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
12/13/2016	Mother	Pending	Pending
Comments:	The mother was arrested for criminally negligent homicide on 12/13/16 for the death of the subject child. The mother remains incarcerated at this time.		

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 Unavaliable	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 family was offered and provided with preventive services. Preventive services remain in place at the conclusion of the investigation.

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:
The maternal aunt gave birth to a baby during the investigation. Preventive services were offered and accepted by the family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother's paramour was provided crisis services immediately after the death of the subject child. Grief services were offered to the family during the investigation and a preventive services cases was opened.

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?	No
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?	N/A
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)	Status/Outcome	Compliance Issue(s)
05/06/2016	14236 - Other Child - cousin, Male, 2 Years	14232 - Unrelated Home Member, Female, 24 Years	Inadequate Guardianship	Unfounded	No
	14236 - Other Child - cousin, Male, 2 Years	14237 - Other Adult - Other child's father, Male, 27 Years	Other	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14238 - Aunt/Uncle, Male, 24 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14232 - Unrelated Home Member, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14237 - Other Adult - Other child's father, Male, 27 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14237 - Other Adult - Other child's father, Male, 27 Years	Inadequate Guardianship	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14238 - Aunt/Uncle, Male, 24 Years	Inadequate Guardianship	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14238 - Aunt/Uncle, Male, 24 Years	Parents Drug / Alcohol Misuse	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14232 - Unrelated Home Member, Female, 24 Years	Other	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14232 - Unrelated Home Member, Female, 24 Years	Parents Drug / Alcohol Misuse	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14237 - Other Adult - Other child's father, Male, 27 Years	Parents Drug / Alcohol Misuse	Unfounded	
	14236 - Other Child - cousin, Male, 2 Years	14238 - Aunt/Uncle, Male, 24 Years	Other	Unfounded	

Report Summary:
The mother, MA, and MGM were added to a report made on 5/6/16 regarding other family members (OFM) and their two year old son that were residing in the MGM's home at the time. The report was a COI issued from Clinton County Family Court. A subsequent report was received on 5/16/16 and consolidated with the 5/6/16 report alleging IG, IF/F/S,

and PD/AM of the OFM. The report alleged the OFM were using drugs in the presence of the two year old, that the two year old was not provided with meals, and was unattended when the OFM was high. The report also alleged physical violence with the OFM. During the course of the investigation, the OFM had moved out of the MGM's home.

Determination: Unfounded | **Date of Determination:** 07/20/2016

Basis for Determination:
No credible evidence was found to substantiate the allegations that the extended family was abusing or maltreating the two year old son. Further, CCDSS did not find credible evidence to support that the extended family members were using drugs while caring for their two year old son. The two year old son was found to be of healthy weight and up to date with well child exams and immunizations. CCDSS also found no credible evidence that the extended family engaged in physical violence in the presence of their two year old child. The subject child was also assessed during this investigation and no evidence of abuse or maltreatment was found as it relates to his care.

OCFS Review Results:
CCDSS gathered sufficient information through interviews with the subjects, household members, and other collateral contacts to support their decisions of safety, risk of future abuse and maltreatment, determination, and service needs. Home visits were made to the maternal grandmother's residence and residences of other family members when extended family members moved. While the subject child was not an alleged or maltreated child during this investigation, CCDSS gathered information from caretakers, medical personnel, and service providers to fully assess his care.

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)
09/23/2015	14257 - Deceased Child, Male, 1 Years	14255 - Grandparent, Female, 43 Years	Inadequate Guardianship	Unfounded	No

Report Summary:
On 9/23/15 the maternal grandmother was named as a subject of a CPS report regarding the subject child. The maternal aunt, who at the time was 17 years old, was also added to the report. The mother and another maternal aunt were also listed on the report with an unknown role. The report alleged Inadequate Guardianship due to the deplorable conditions of the home. Further the report alleged the family had eight dogs in the home, the home had a foul odor, there was trash laying around the home, and the home was dirty.

Determination: Unfounded | **Date of Determination:** 12/02/2015

Basis for Determination:
No credible evidence was found to substantiate the allegations of Inadequate Guardianship of the subject child by the maternal grandmother. CCDSS made several home visits during the course of the investigation and found the condition of the home not to pose a health or safety concern for the subject child. CCDSS also corroborated information about the care of the subject child and the maternal aunt through interviews with household members, extended family, and collateral contacts.

OCFS Review Results:
CCDSS gathered sufficient information through interviews with household members and extended family, home visits, and collateral contacts to support case decisions of safety, risk of future abuse and maltreatment, determination, and service needs.

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)
05/09/2014	14252 - Aunt/Uncle, Female, 16 Years	14250 - Grandparent, Female, 42 Years	Lack of Medical Care	Indicated	No

14252 - Aunt/Uncle, Female, 16 Years	14250 - Grandparent, Female, 42 Years	Lack of Supervision	Indicated
14252 - Aunt/Uncle, Female, 16 Years	14250 - Grandparent, Female, 42 Years	Inadequate Guardianship	Indicated

Report Summary:
On 5/9/14 the maternal grandmother was named as the subject of a CPS report regarding the maternal aunt who was 16 years old at that time. The report alleged Inadequate Guardianship, Lack of Medical Care, and Lack of Supervision of the maternal aunt. The maternal aunt had been hospitalized for mental health issues. After the first hospitalization in January of 2014, the maternal grandmother failed to follow up with the appropriate medical and mental health services for the maternal aunt. The report further alleged that the maternal grandmother had little control of the maternal aunt as the maternal aunt comes and goes from the home as she pleases and was dating a 23 year old man.

Determination: Indicated | **Date of Determination:** 07/18/2014

Basis for Determination:
CCDSS found credible evidence to substantiate the allegations of Inadequate Guardianship and Lack of Medical care of the maternal aunt by the maternal grandmother. The maternal grandmother failed to ensure the maternal aunt received the necessary medical and mental health follow up recommended from a hospitalization in January 2014. As a result, the maternal aunt was again hospitalized in May 2014 due to mental health concerns. The allegation of Lack of Supervision was unsubstantiated as no credible evidence was found to support the maternal grandmother allowed the maternal aunt to date a 23 year old male or provide inadequate supervision. The family was receiving community based services.

OCFS Review Results:
CCDSS gathered sufficient information to support case decisions of safety, risk of future abuse and maltreatment, determination, and service needs. Information was gathered through interviews with the family, household members, extended family, and other collateral sources of information. Further, CCDSS maintained contact with mental health providers to ensure the maternal aunt was receiving the necessary follow up care after her discharge from the hospital. A referral for preventive services was also made for the family. At the conclusion of the investigation, the family was receiving community based services, but was not responding to efforts made by preventive services.

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)
12/19/2013	14244 - Aunt/Uncle, Female, 16 Years	14243 - Grandparent, Female, 41 Years	Educational Neglect	Indicated	No
	14244 - Aunt/Uncle, Female, 16 Years	14243 - Grandparent, Female, 41 Years	Inadequate Guardianship	Indicated	

Report Summary:
On 12/19/13 the maternal grandmother was named as an alleged subject of a CPS report alleging Inadequate Guardianship and Educational Neglect of the maternal aunt. The report alleged the maternal aunt had missed 31 days of school and was failing her courses as a result. The maternal grandmother had been made aware of the absences and failed to follow any recommendations to improve the maternal aunt's attendance.

Determination: Indicated | **Date of Determination:** 04/30/2014

Basis for Determination:
CCDSS found credible evidence to substantiate the allegations of Inadequate Guardianship and Education neglect of the maternal aunt by the maternal grandmother. The maternal aunt admitted to missing school and provided several excuses. While the maternal grandmother acknowledged the maternal aunt missed some days of school, the reasons for the absences did not match the significant amount of school the maternal aunt missed. Throughout the investigation, the maternal aunt continued to miss school with no intervention by the maternal grandmother.

OCFS Review Results:
CCDSS gathered sufficient information to support case decisions of safety, risk of future abuse and maltreatment, determination and service needs. While the family was not engaged and evasive with CCDSS during the investigation, CCDSS gathered information from interviews with family and household members, extended family members, and collateral contacts. Further CCDSS assessed the safety of the subject child and an infant cousin who were also residing in the home at times during 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

The mother was named as a child in eight CPS reports between 8/27/98 and 3/14/07. The mother's paramour was name as a child in six CPS reports between 12/18/92 and 8/20/08. The birth father was listed in five CPS reports as a child between 9/2/08 and 8/8/11. He was also listed in a report dated 8/18/10 as an alleged subject, although he was minor at the time, regarding another family with allegations of Inadequate Guardianship. The report was indicated, but the allegations against the birth father were unsubstantiated. The maternal grandmother was listed on 11 CPS reports between 8/27/98 and 2/15/13 with allegations of Inadequate Guardianship, Sexual Abuse, Child's Drug/Alcohol Use, Lack of Medical Care, Educational Neglect, Excessive Corporal Punishment, and Lacerations/Bruises/Welts. Five report were indicated with the maternal grandmother as the confirmed subject. The maternal grandmother also had an open preventive services case from 12/15/05 through 1/16/07. The preventive services case listed the maternal grandmother and the mother's half sibling. Mental health and education concerns for the mother's half sibling were addressed through the preventive services case. Although the mother's half sibling disengaged in mental health services, she had improved her school attendance and the case was closed on 1/16/07.

Known CPS History Outside of NYS

N/A

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services 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

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