Report Identification Number: AL-16-022

Prepared by: Albany Regional Office

Issue Date: Jul 07, 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: 17 year(s)
Jurisdiction: Schenectady
Gender: Female
Date of Death: 09/15/2016
Initial Date OCFS Notified: 09/16/2016

Presenting Information

On 9/16/2016 SCR received a report regarding the death of the 17-year-old female SC. The report alleged SC had been shot, and it was unknown if she had committed suicide. It was also unknown to whom the gun belonged or how SC gained access to the weapon. It was alleged that SM was home when the incident occurred and failed to take active measures to prevent the shooting from taking place.

Executive Summary

On 9/15/2016 the SC was shot in the head with a gun by her boyfriend and died as a result. The incident occurred in SC's family's residence. The night of the fatal incident, Schenectady Police Department requested that Schenectady County Department of Social Services (SCDSS) meet the investigators at the Youth Advisory Board while LE conducted interviews. LE conducted interviews of the SS's and SM, all of whom were in the home at the time of the fatal incident. SCDSS was not allowed by LE to participate in the interviews, but SCDSS workers were provided copies of statements. An SCR report was made the morning after SC's death. LE was selective in sharing information due to the nature of the criminal investigation; however, they informed SCDSS there was no concern that SM had any part in SC's death nor could have prevented it. SCDSS learned that SC was shot by her boyfriend, who was not a member of the household or family.

The SCR report alleged SM failed to take protective measures to prevent the fatal shooting from taking place, with allegations of DOA/Fatality and IG regarding SC. There were no reported concerns for the other children in the home. The ME determined the official cause of SC's death was brain injury due to gunshot wound to the head, and the time of death was 11:50pm.

SCDSS determined there were no immediate safety concerns throughout the investigation for the two SS's and SC's child, all of whom resided in the home. SC had two other adult siblings who did not reside in the home. The putative father of SC's child was awarded temporary custody and the child went to live in his home. SCDSS completed home visits (HV) on the date of the report to assess safety of all the surviving children.

SCDSS made adequate and timely assessments of safety for the surviving children on an ongoing basis. SCDSS offered assistance with housing, bereavement services, and funeral expenses which were accepted by the family. SCDSS opened a Preventive case to provide daycare services for SC's child, and that case remained open with that child, his putative father, and the putative father's mother who is a familial resource.

SC's boyfriend, the alleged perpetrator, was arrested and later indicted in a Grand Jury trial, charged with Murder in the 2nd Degree. He remained in custody at Schenectady County Jail at the time of this report. Despite diligent efforts, SCDSS was unable to obtain full details surrounding SC's death due to the ongoing criminal investigation.

SCDSS accurately determined that there was insufficient credible evidence to substantiate the allegations against SM, and the report was unfounded. There were adequate services offered and provided to the family. The Risk Assessment Profile (RAP) was completed in a timely manner but was found to be inaccurate. Upon notification by OCFS, SCDSS modified the incorrect answers in a progress note as an addendum to the RAP; however, the question

pertaining to SM's history of mental illness was still reflected inaccurately. The CPS history review was incomplete in regard to the family's involvement with CPS in Georgia. During this investigation, SCDSS requested the out-of-state records from Rensselaer County LDSS but did not receive the information as records were destroyed in a flood. SCDSS failed to request records directly from the state of Georgia in current and previous investigations.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
CPS completed activities and worked with the family commensurate with case circumstances.

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 investigation was completed adequately, and LDSS had sufficient information to make the determination to unsubstantiate all allegations and unfound the report.

Required Actions Related to the Fatality

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

Issue:	Adequacy of case recording
Summary:	The Risk Assessment Profile (RAP) was completed and approved inaccurately. After this was brought to their attention, SCDSS wrote a progress note as an addendum that corrected some of the errors, but not all.
Legal Reference:	18 NYCRR 428.5(c)
Action:	SCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 30 days that identifies what

	action it has taken or will take to see that all RAP questions are completed accurately.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/15/2016 **Time of Death:** 11:50 PM

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

County where fatality incident occurred: SCHENECTADY
Was 911 or local emergency number called? Yes
Time of Call: 11:30 PM
Did EMS to 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

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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		17 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Other Child	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Other Household 1	Father	No Role	Male	48 Year(s)
Other Household 2	Other Child	No Role	Male	17 Year(s)

LDSS Response

Following the fatality, LE conducted interviews of SM and SS's but would not allow SCDSS to participate or observe due to the nature of criminal investigation. Upon receipt of report, SCDSS completed a HV to SC's child's PGM to assess his safety and deemed him safe. SCDSS also completed a HV to MGGM and saw SM and the two SS's who resided in the home. They too were deemed safe. SCDSS then offered to assist with burial costs, housing, and grief counseling. SCDSS followed up on a later date to inquire about the status of the family's grief counseling. SM reported she'd been seeing her therapist and had set up appointments for the children (CHN), but SM declined to sign releases. SCDSS obtained immunization records for SC, SC's child and SS's which revealed no concerns. SM declined to sign any additional releases for the SS's and requested that they not be interviewed in school.

Two MDT meetings were held to discuss the case and provide updates. LE continued to only provide limited information to SCDSS regarding the fatal incident due to the ongoing criminal investigation. LE stressed to SCDSS the importance of CW's positive interactions with the family so as not to compromise the criminal investigation. LE shared photographs of the home where the incident occurred, which was family's residence. SCDSS documented the content of the photographs and noted concerns for the condition of the home.

Throughout investigation, SCDSS made follow-up contacts with the family members. SM and SS's remained housed by family and later a friend of the family's, while SC's child remained in the care of his putative father and PGM. The putative father of SC's child was awarded temporary custody while paternity was in process of being established. A Grand Jury was convened and the alleged perpetrator (SC's boyfriend) was indicted on the charge of Murder in the 2nd Degree and remained in custody at Schenectady County Jail at the time 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
Comments: Investigation was conducted by SCDSS MDT and collaborated regularly with LE.

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
031821 - Deceased Child, , 17 Yrs	031822 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
031821 - Deceased Child, , 17 Yrs	031822 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Case Planners	☐	☐	☐	☒
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Explain as necessary:
There were no safety factors present therefore no safety plan was needed. Removal of the surviving children was not necessary. BF was named in report but not interviewed; however, diligent efforts were made by SCDSS to do so. SCDSS failed to contact the school as a collateral contact.

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: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/19/2016	There was not a fact finding	CustodyGuardianship assigned to relative or non-relative (Article 6 non-foster care)
Respondent:	None	
Comments:	Following the death of SC, petitions requesting custody of the SC's child were filed by the child's biological father (not mother's boyfriend) and the SC's mother. The biological father was awarded temporary custody and the process to establish paternity was established.	

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
09/17/2016	SC's boyfriend	Pending	pending
Comments:	Grand Jury trial was held November 2016 and SC's boyfriend was indicted on the charge of Murder in the 2nd Degree. He was remanded to Schenectady County Jail.		

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	☐	☐	☐	☐	☐	☒	☐

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? No

Explain:
SCDSS offered immediate service needs, such as housing and counseling; however, these services were not accepted by the family until later in the investigation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Alternate housing in response to the fatality was offered and declined. Family later accepted services to assist in locating new housing. Family also accepted assistance with burial services, daycare, and grief counseling.

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?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
Was the child acutely ill during the two weeks before death?	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)
12/30/2015	11555 - Other Child - SC's child, Male, 1 Years	11554 - Mother, Female, 39 Years	Inadequate Guardianship	Unfounded	Yes
	11555 - Other Child - SC's child, Male, 1 Years	11554 - Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unfounded	
	11557 - Sibling, Female, 10 Years	11554 - Mother, Female, 39 Years	Inadequate Guardianship	Unfounded	
	11558 - Sibling, Male, 6 Years	11554 - Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	11553 - Deceased Child, Female, 17 Years	11554 - Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	11553 - Deceased Child, Female, 17 Years	11554 - Mother, Female, 39 Years	Inadequate Guardianship	Unfounded	
	11555 - Other Child - SC's child, Male, 1 Years	11554 - Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	11556 - Sibling, Female, 10 Years	11554 - Mother, Female, 39 Years	Inadequate Guardianship	Unfounded	

11556 - Sibling, Female, 10 Years	11554 - Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unfounded
11557 - Sibling, Female, 10 Years	11554 - Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unfounded
11558 - Sibling, Male, 6 Years	11554 - Mother, Female, 39 Years	Inadequate Guardianship	Unfounded
11558 - Sibling, Male, 6 Years	11554 - Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unfounded
11553 - Deceased Child, Female, 17 Years	11554 - Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unfounded
11556 - Sibling, Female, 10 Years	11554 - Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded
11557 - Sibling, Female, 10 Years	11554 - Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded

Report Summary:
SCR report received with allegations of IG against SC and IF/C/S against SC and SM regarding the infant. It was alleged that SC prostituted in the home, and that men came and went while the infant was present. The home was deplorable, strewn with garbage and debris which posed a health and safety hazard to the child. SM was aware of the situation and failed to protect the child.

Determination: Unfounded **Date of Determination:** 02/03/2016

Basis for Determination:
LDSS found no evidence of prostitution activity in the home, and SM denied allegations. SM and SC reported that the landlord likely made the report after seeing one of the SC's boyfriends climbing through a window. The home was messy and unorganized, but the open Preventive case was addressing the issue. The condition of the home did not rise to a level of serious concern for the infant. SC was using marijuana and had untreated MH issues. SC was non-compliant with treatment, and SM had temporary custody of SC's child. Family struggled with persistent homelessness, and the Preventive case also targeted these problems.

OCFS Review Results:
There were very limited notes to gather information about casework activities. The 7-day safety assessment was never completed. SC was never spoken with regarding the allegations. The children in the home were never interviewed, the source never contacted, collateral contacts never made, and BFs never notified of the report. LDSS briefly visited the home and the family was being evicted, but there was no plan discussed with the family. Although the case was referred to the Prevention worker for these ongoing issues, the allegations were never adequately addressed.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
Not enough information was gathered to support a determination. LDSS did not contact any collaterals and none of the children were interviewed. The aspect of the report which mentioned prostitution by SC was not explored with SC, the siblings, or the community.

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

Action:
This issue was identified as a finding from SCDSS OMA years 1 and 2. The strategies and actions developed by SCDSS to address this issue are included in their current Program Improvement Plan. An additional plan is not required.

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

Not enough information was gathered to support a determination. LDSS did not contact any collaterals and none of the children were interviewed. The aspect of report which mentioned prostitution by SC was not explored with SC, the siblings, or the community.

Legal Reference:

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:

This was identified in a prior fatality report issued in 2015. The actions and strategies developed by SCDSS are included in their current Program Improvement Plan. No additional Corrective Action is required.

Issue:

Face-to-Face Interview (Subject/Family)

Summary:

LDSS did not interview any of the children, all of whom were named on the report and resided in the home.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(a)

Action:

This issue was previously identified in SCDSS OMA years 1 and 2. The actions and strategies developed SCDSS are part of their current Program Improvement Plan. No additional corrective actions are required.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

LDSS did not complete a 7-day safety assessment.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

LDSS will complete all safety assessments in the amount of time required. This issue is have been identified throughout the report and will be required to be addressed once. The actions and strategies developed by SCDSS will be included in their current Program Improvement Plan.

Issue:

Failure to provide notice of report

Summary:

LDSS failed to notify, interview, and add the BFs to the report.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

This is an issue which is identified other times through out this report. SCDSS will only have to address this issue once. The actions and strategies will be included in their current Program Improvement Plan. A Corrective Action is required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/30/2015	11552 - Other Child - Mother's child, Male, 1 Years	11550 - Mother, Female, 17 Years	Inadequate Guardianship	Unfounded	Yes
	11552 - Other Child - Mother's child, Male, 1 Years	11550 - Mother, Female, 17 Years	Inadequate Food / Clothing / Shelter	Unfounded	

	11552 - Other Child - Mother's child, Male, 1 Years	11551 - Grandparent, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:
This was a subsequent report alleging IF/C/S, IG, and PD/AM against SM regarding four of her children and her grandchild (SC's child). Report alleged SM was abusing alcohol to the point of intoxication while caring for the children, and that she was aware SC was prostituting out of the home yet failing to intervene. Report further stated the home was in deplorable condition with no clear paths, human feces on the floors and walls, small items accessible to young children, and infested with bugs, all of which posed a safety hazard to the children.

Determination: Unfounded | **Date of Determination:** 03/07/2016

Basis for Determination:
SM had history of an unkempt home, monitored by an SCDSS Preventive Services worker. Progress notes reflected that most times the home was seen, it met a minimal degree of care, but on one occasion there were small items accessible to the toddler and no safety plan was made nor was this promptly addressed. LDSS could not prove that SC was prostituting, but it was never addressed with SC nor questioned by collaterals. At home visits, SM was not witnessed to be intoxicated and it could not be proven that her admitted use impacted her ability to care. The minimal amount of information gathered was the basis for LDSS to conclude that they had insufficient grounds to substantiate the allegations.

OCFS Review Results:
There were no collaterals contacted, including source. None of the children were interviewed. Not enough information was gathered to support a determination. The 7-day safety assessment wasn't completed on time. Seven days into investigation there were small objects on the floor which posed an immediate safety hazard to the toddler, and a safety plan wasn't made nor was there a follow up home visit to check progress until nine days later. There were very few progress notes. The case closing summary note stated long-term services were in place; however, the Preventive case was closed two weeks prior to case closing and no long-term case was open at the time.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
LDSS failed to contact the source.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
This issue was identified in SCDSS OMA for years 1 and 2 and actions and strategies have been submitted by SCDSS. The issue and SCDSS actions and strategies to address the issue are included in SCDSS current Program Improvement Plan. No Corrective Action is required.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
Not enough information was gathered to support a determination. LDSS did not contact any collaterals and none of the children were interviewed. The aspect of report which mentioned prostitution by SC was not explored with SC, the siblings, the source, or the community.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
This issue was previously identified in a 2015 fatality report. Schenectady County has identified actions and strategies which are being implemented as part of their part of their current Program Improvement Opportunity Plan. No Corrective

Action is required.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
LDSS did not interview any of the children, all of whom were named on the report and resided in the home.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
This issue was identified as a finding in Schenectady County's OMA years 1 and 2. SCDSS has submitted a Corrective Action Plan which is part of their current Program Improvement Opportunity Plan. No Corrective Action is required.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
LDSS did not submit a 7-day safety assessment until 33 days into investigation. Within 7 days, LDSS discovered small objects on the floor accessible to the toddler and this immediate safety hazard was not reflected in an approved 7-day safety assessment. There was no follow up to check if the hazard had been mitigated in a timely manner, as LDSS didn't make a home visit until 9 days later.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
LDSS will take immediate action to address serious identified safety concerns. LDSS will complete all safety assessments in the amount of time required. The timeliness of the completion of seven-day safety assessments is identified more than once in this report. Only one corrective action is required.

Issue:
Failure to provide notice of report
Summary:
LDSS failed to notify, interview, and add the BFs to the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
This is a finding identified several times within this report. Only one corrective action is required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/08/2015	11549 - Other Child - Mother's child, Male, 1 Years	11547 - Mother, Female, 16 Years	Lack of Medical Care	Unfounded	Yes

Report Summary:
SCR report alleged SC's infant had a chronic cough for one week and was prescribed medication. The infant's medication ran out and SC failed to obtain a refill and bring the infant to see a doctor. Allegations were LM against SC regarding her infant.

Determination: Unfounded | **Date of Determination:** 10/08/2015

Basis for Determination:
LDSS found that SC exaggerated the infant's cough when making a medical appointment for him in order to get the infant seen right away for what she thought was a spider bite. LDSS found that the infant had a minor cold, with a previous history of wheezing. SC did not show for the appointment, nor show for a rescheduled appointment that same

day. The following day, SM scheduled an appointment with a different pediatrician and had the child seen. The infant received the necessary medical care and medication for the spider bite and cough.

OCFS Review Results:
Investigation was allegation focused despite the extensive history. There were ongoing concerns for SC's MH and substance abuse (SA) that were never addressed nor inquired about with the Preventive worker. The 7-day safety assessment was late and incorrect. LDSS did not contact the medical provider who saw the infant, thus inaccurately assessing imminent safety. All risk factors were not addressed therefore the RAP was inaccurate. Both BFs were not informed, interviewed, or added to report. No collaterals were contacted, except the source.

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

Issue:
Failure to provide notice of report
Summary:
LDSS failed to notify, interview, and add the BFs to the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
The issue is addressed in the review of other investigations included in this report. The actions and strategies to be developed by SCDSS will be added to their current Program Improvement Plan. no Corrective Action is required.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
LDSS did not address the underlying safety concerns including the SC's untreated MH and SA concerns. There was insufficient documentation of contact with Prevention worker to address these issues. The SC's non-compliance with treatment wasn't reflected in the safety assessments, RAP or determination. No collaterals and not enough information was obtained to support their determination.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
This issue had been identified in the review of other investigations included in this report. SCDSS actions and strategies to address the issue will be added to their current Program Improvement Plan.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
LDSS did not address the underlying safety concerns including the SC's untreated MH and SA concerns. There was insufficient documentation of contact with Prevention worker to address these issues. The SC's non-compliance with treatment wasn't reflected in the safety assessments, RAP or determination. No collaterals and not enough information was obtained to support their determination.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
This issue has already been identified in a prior fatality report and the strategies and actions to address the issue are included in SCDSS current Program Improvement Plan. No Corrective Action is required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)

11/05/2014	11541 - Deceased Child, Female, 16 Years	11542 - Mother, Female, 38 Years	Educational Neglect	Unfounded	Yes

Report Summary:
SCR report received with concerns SC refused to attend school and was failing as a result. It also alleged that SM failed to intervene, which resulted in SC's continued truancy. Allegations were EdN against SM regarding SC.

Determination: Unfounded **Date of Determination:** 12/30/2014

Basis for Determination:
SC failed to attend school nearly every day of the school year, and SM was unaware. SC often left her infant in SM's care, not informing SM of her whereabouts. SC admitted to regular marijuana use. LDSS found SC to be unfit to care for her infant due to ongoing SA, MH, and behavioral concerns. SM was granted temporary custody of SC's infant and she filed a PINS. A safety plan was put into place where SC could not be the sole caregiver. The case was UNF and opened for services to address SC's needs, the safety of the infant, and SM's needs, including the cleanliness of the home and ensuring SM's CHN are safe and appropriately supervised. LDSS monitored rather than filing neglect against SC.

OCFS Review Results:
LDSS did not fully explore what actions the school took in getting SM involved with SC's attendance concerns or address sibling's attendance issues. SM had history of EdN indications. There is no documentation of legal consult. A separate report on SC regarding her infant should have been made for LS, IG, and PD/AM. No referral was made for SM for a SA evaluation, despite several alcohol bottles being observed at the home throughout the investigation. BF was never contacted, and one of the CHN disclosed he was smoking marijuana in their presence. There were no attempts to speak with infant's BF or his family. No police records were requested to verify SM was filing missing persons reports

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

Issue:
Failure to provide notice of report

Summary:
LDSS failed to notify, interview, and add the BF to the report.

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

Action:
This issue has been identified several times within this report and only will be required to be addresses once.

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
LDSS failed to fully explore attendance/truancy issues with both the school and SM; yet, all of the CHN listed on the report were noted as having those issues. LDSS failed to contact BFs. LDSS failed to address possible SA concerns with SM nor make referral for evaluation. LDSS did not follow up with LE to ensure SM was filing missing persons reports each time SC could not be located.

Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:
This issue was previously identified in a 2015 fatality report and actions developed by SCDSS to address the issue are included in their current Program Improvement Plan. No Corrective Action is required.

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

Summary:
LDSS should have made an SCR report regarding SC and her infant, due to the many concerns that arose during the

investigation regarding SC's mental health, substance abuse, behaviors, supervision, cleanliness, defiance and overall non-compliance.

Legal Reference:

SSL 413 and 415

Action:

Mandated reporters will fulfill their requirement of reporting any suspected safety concerns for children to the SCR. A corrective action for this finding is required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/28/2014	11540 - Sibling, Male, 5 Years	11537 - Mother, Female, 37 Years	Inadequate Guardianship	Unfounded	Yes
	11540 - Sibling, Male, 5 Years	11537 - Mother, Female, 37 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:

SCR report alleged SM dragged five year old SS across the floor. As a result, SS sustained an abrasion that was four inches long and bleeding. Report contained allegations of IG and L/B/W.

Determination: Unfounded | **Date of Determination:** 06/19/2014

Basis for Determination:

LDSS spoke with the alleged maltreated SS but SS was unable to offer an explanation for the injury. LDSS spoke with SM and other siblings in the home. Various explanations were given for the injury; however, everyone denied SM caused the injury. SM was directed to seek medical attention for the child and reported she had taken child to ER to be treated. Case remained open for long-term Prevention services and continued to be monitored.

OCFS Review Results:

Investigation was allegation focused despite the extensive history. There was no evidence that LDSS followed up with medical collaterals to verify that SM actually took SS for treatment as directed. BF was never contacted.

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

Issue:

Failure to provide notice of report

Summary:

Investigation was allegation focused despite the extensive history. There was no evidence that LDSS followed up with medical collaterals to verify that SM actually took CH for treatment as directed. BF was never contacted. LDSS failed to contact medical personnel after directing SM to take her CH for medical treatment, and instead took SM's word that she had taken CH for medical treatment.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

The issues identified above are the same issues which are identified several times in this report. This issue is not part of SCDSS current Program Improvement Plan and will required a corrective action.

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

Investigation was allegation focused despite the extensive history. There was no evidence that LDSS followed up with medical collaterals to verify that SM actually took CH for treatment as directed. BF was never contacted. LDSS failed to contact medical personnel after directing SM to take her CH for medical treatment, and instead took SM's word that she

had taken CH for medical treatment.

Legal Reference:

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:

This issue was previously identified in a prior fatality report and Schenectady County has identified actions and strategies which are part of their current Program Improvement Plan. No Corrective Action is needed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/09/2014	11531 - Deceased Child, Female, 15 Years	11532 - Mother, Female, 37 Years	Educational Neglect	Unfounded	Yes
	11531 - Deceased Child, Female, 15 Years	11532 - Mother, Female, 37 Years	Lack of Supervision	Unfounded	
	11531 - Deceased Child, Female, 15 Years	11532 - Mother, Female, 37 Years	Inadequate Guardianship	Unfounded	

Report Summary:

SCR report contained allegations of EdN, LS & IG. Report alleged SC had missed 30 days of school and was late 25 times. SM was not properly supervising SC to ensure she went to school.

Determination: Unfounded **Date of Determination:** 02/09/2014

Basis for Determination:

SC was placed on probation for not attending school. As LDSS was involved, SC's attendance improved. The minimal amount of information gathered was the basis for the unsubstantiated determination.

OCFS Review Results:

LDSS failed to fully explore attendance issues with both the school and SM. All children listed on the report were noted as having attendance issues and LDSS did not obtain attendance records. LDSS failed to appropriately address possible SA concerns with SM and a referral for evaluation was never made. BF was never added to the case or notified. LDSS gathered an insufficient amount of information to support their determination.

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

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

LDSS failed to fully explore attendance/truancy issues with both the school and SM; yet, all of the CHN listed on the report were noted as having those issues. LDSS failed to contact BFs. LDSS failed to address possible SA concerns with SM or make referral for evaluation.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

Action:

This issue was a prior finding in a 2015 fatality report. The actions and strategies identified by SCDSS to address this issue are included in their current Program Improvement Plan. No Corrective Action is required.

Issue:

Failure to provide notice of report

Summary:

LDSS failed to notify, interview, and add the BF to the report.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:
This is a finding already identified in this report. Only one corrective action is required.

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

10/26/2005-12/13/2005 SM IND for LS, and UNF for IG & L/B/W.
3/29/2006-6/13/2006 SM IND for OTH.
3/13/2007-5/9/2007 SM UNF for IF/C/S, IG & PD/AM.
5/29/2007-7/31/2007 SM UNF for IG & LS. BF IND for LS.
9/21/2007-12/11/2007 SM IND for IG, IF/C/S & LS. Case open-CPS required. Neglect petition filed, supervision orders. Custody of children was transferred to relative due to ongoing concerns with SM.
9/3/2008-10/9/2008 SM UNF for IG & LMC.
4/10/2010-5/6/2010 SM UNF for IF/C/S, XCP, IG & L/B/W.
7/26/2010-10/7/2010 SM UNF for XCP & L/B/W.
1/5/2012-3/8/2012 SM IND for IF/C/S, IG & LS.
3/23/2012-5/22/2012 SM IND for IG, EdN, B/S & LMC. Closed, services refused/unable to take legal action.
11/20/2012-2/13/2013 SM UNF for IF/C/S, IG & LS.
5/23/2013-7/26/2013 SM IND for IF/C/S, IG & EdN. Case open, CPS required.

Known CPS History Outside of NYS

The family had CPS history in the state of Georgia, but full details are unknown. In 2005, CPS in Georgia requested that CPS in New York open a Preventive Services case by way of Interstate Compact for the Placement of Children (ICPC) due to a history of concerns for lack of supervision and drug use. In this fatality investigation, SCDSS requested records from Rensselaer County LDSS (who had history with the family at that time in 2005) and from New York State's ICPC Department. These records were destroyed in a flood.

Required Action(s)

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

Preventive Services History

11/16/2005 Georgia CPS requested to open preventive services in Rensselaer County for SM and 3 children. A preventive case was never opened because there was already an open CPS investigation.
11/2/2007-8/10/2009 A Services case opened for long term monitoring due to a neglect petition that was filed against SM for ongoing concerns of LS, I/F/C/S and overall failure to provide a minimal degree of care to her children. Children were placed in the custody of maternal great aunt to mitigate the serious concerns for the children with SM. LDSS monitored SM's MH and substance abuse (SA). Eldest SS was placed due to PINS behaviors. SS was later discharged to relatives in GA. Case closed when orders expired.
9/20/2011-12/5/2011 A Services case opened as SM and the children were homeless. Goals were to reengage SM in MH treatment and Early Intervention for SM's youngest CH. Case closed, housing secured.
8/29/2013-9/30/2014 A Services case opened with concerns that SM and SC struggled to get along, and SM struggled to maintain an appropriate living environment for herself and the children. Case closed regardless of ongoing concerns.

1/2/2015-2/22/2016 A Services case opened with concerns for SC regarding her child (SA, untreated MH, out of control behaviors, and poor parenting skills). Concerns for SM regarding PINS follow-through and home keeping. Case closed abruptly before goals met.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article - 7 PINS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	SM filed a PINS petition for SC in November 2014. Several court dates were missed by SM and SC and the judge dismissed the petition.	

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/12/2014	There was not a fact finding	Petition Dismissed
Respondent:	None	
Comments:	SM filed for and was awarded temporary joint custody of SC's child in December 2014. Later court dates were missed by both SM and SC; therefore, the judge dismissed the petition and SM no longer shared custody.	

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