Child Fatality Report

Report Identification Number: BU-17-025

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

Issue Date: Mar 12, 2018

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Chautauqua
Gender: Male
Date of Death: 09/23/2017
Initial Date OCFS Notified: 09/26/2017

Presenting Information

On 9/26/17, an OCFS-7065 Agency Reporting Form was received from Chautauqua County Department of Social Services (CCDSS) regarding the death of a 2-year-old male child (SC) who was involved in an open CPS investigation at the time of his death. The SC was an otherwise healthy child with no known preexisting medical conditions, and his cause of death was undetermined.

Executive Summary

This fatality report concerns the death of a 2-year-old male (SC) that occurred on 9/23/17. SC died during an open CPS investigation that was received by Chautauqua County Department of Social Services (CCDSS) with concerns unrelated to the fatality. A completed 7065 Reporting Form was sent to OCFS on 9/26/17. Upon learning of SC's passing, CCDSS promptly began to gather information surrounding the circumstances leading up to his death. An autopsy was performed and the final report of examination noted the cause of death as undetermined and the manner of death as natural.

SC resided with BM, BF, MGF, an adult cousin (OA), and three SS: 11, 10, and 5 years old. Family members explained SC was an otherwise healthy child with no preexisting medical conditions; however, it was reported by family members that SC had a fever and rash the night before his death, and was given children's Tylenol to alleviate symptoms. The morning of 9/23/17, SC's fever had gone down and the parents and MGF reported SC was acting normally. MGF and OA were at home throughout the late morning, and the parents went out. Regardless of adults present, interviews revealed SC had been in the care of the 11yo SS. At some point during the day, SC collapsed and the 10yo SS retrieved OA for help. OA brought SC to a nearby fire station, where EMS was called and resuscitation efforts began. SC was brought by ambulance to the hospital, where he was later pronounced deceased.

Upon speaking to the ME and hospital staff, CCDSS discovered there was no physical trauma to SC's body, and no explanation could be provided as to why SC died; the ME hoped more would be known once the autopsy and toxicology tests were completed. CCDSS obtained information from SC's pediatrician that noted SC having been diagnosed as failure to thrive and underweight in 2016, which was the last time he was seen by his doctor. CCDSS did not discuss these concerns with the parents. There were also concerns surrounding the parents frequently leaving the three younger CHN in the care of SS1, and CCDSS did not explore if an adult went with the CHN to the library the date of SC's death, nor if any of the SS informed an adult SC had not appeared well while there. CCDSS did not explore whether or not SS1 had the ability to appropriately supervise and care for her younger siblings. Further, there were considerable concerns regarding deplorable home conditions in which the CHN were living at the time of SC's death. The family agreed to stay with a relative and not return to the home, and CCDSS deemed the SS safe. At the close of the initial CPS investigation, CCDSS noted there was still no explanation provided by medical professionals as to why or how SC died. Since there were no apparent signs of physical abuse or maltreatment, CCDSS concluded SC's death was not suspicious and an SCR report did not need to be made. CCDSS indicated the initial CPS report and closed.

PIP Requirement

CCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) CCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, CCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **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:
Recent pediatric records reflected referrals and recommendations for the SS, as well as concerns regarding SC's health, but these were not addressed with the parents.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
There were concerns noted by the CHN's pediatrician that were not addressed with the parents prior to case closure.

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: 09/23/2017 **Time of Death:** 04:41 PM

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

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

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	2 Year(s)
Deceased Child's Household	Father	No Role	Male	29 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	48 Year(s)
Deceased Child's Household	Mother	No Role	Female	28 Year(s)
Deceased Child's Household	Other Adult - Cousin	No Role	Male	27 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)

LDSS Response

On 9/25/17, CCDSS submitted a completed 7065 Reporting Form to OCFS regarding the death of SC, which occurred on 9/23/17. At the time of SC's death, there was an ongoing CPS investigation, which began on 9/6/17. A subsequent SCR report was made on 9/23/17; neither of these reports were regarding the fatality. Upon learning of SC's passing from LE, CCDSS promptly began to gather information surrounding the circumstances leading up to his death. CCDSS worked collaboratively with LE to obtain details of forensic interviews that were conducted with family members, including the 3 SS. LE expressed concerns surrounding the home conditions, and noted the home was deplorable with multiple safety hazards. BM and BF met with CCDSS and agreed the family would stay with PGM and PGF at their home due to the concerns.

The 9/6/17 investigation was received with concerns surrounding the parents' failure to supervise the CHN appropriately, and allowing SS1 to act as a caregiver to her younger siblings in an adult's absence. On the date of SC's death, the SS were interviewed and informed CCDSS they walked to the library for an art program. Despite awareness of the concerns alleged in the initial report, CCDSS did not ask follow-up questions as to whether the CHN were with an adult or supervised at the time they went to library; it was learned BM and BF were out visiting a friend, and MGF and OA were at home. While at the library for approximately 15 minutes, according to SS1, SC "turned pale" and "looked dizzy", so SS1 left to bring SC back home. LE reported to CCDSS SC then took a nap, and appeared to be acting normally after he awoke; the length of the nap nor who put SC down to sleep and where was not specified. After he awoke, SC followed one of the SS upstairs to play, while MGF and OA remained downstairs. SS1 reported SC suddenly "fell over". SS1 reported she sat SC up in a chair, and he "couldn't catch his breath", so she told SS2 to get OA. OA immediately went upstairs and brought SC to the nearby fire station, where EMTs began performing CPR on SC and called 911. EMS and LE arrived

shortly thereafter, and SC was transported to the hospital, where he was later pronounced deceased. The record did not reflect if CCDSS asked any of the SS whether they informed the adults at home of SC's behavior at the library upon returning home earlier that day.

CCDSS interviewed BM and BF, and they reported SC had a fever and rash the night prior to his death, so he was given Tylenol. The following morning, SC awoke with much less of a fever and appeared to be acting normally. The parents stated they went to visit a friend and about 20 minutes later got a call from MGF that SC stopped breathing; they went directly to the fire house and then to the hospital. BM and BF expressed SC had no underlying medical conditions and was otherwise healthy. CCDSS obtained pediatric records which reflected SC was diagnosed as failure to thrive in July 2016, and at his last visit in November 2016, he remained underweight and was behind on immunizations. CCDSS did not discuss these concerns with BM of BF.

CCDSS confirmed with LE and medical collateral sources that there were no signs of trauma to SC's body, or any obvious signs of abuse or neglect. CCDSS felt this was sufficient to conclude SC's death was not suspicious. The safety of the SS was assessed, and CCDSS followed up with appropriate collateral contacts, including the ME, local school district, pediatrician, LE, and hospital staff. The final autopsy noted SC's final diagnoses as viral illness, recent fever, acute thymic involution, and hepatoblastoma. The SC's cause of death was listed as undetermined, and the manner of death as natural.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Undetermined if injury or medical cause
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?No
Comments: Chautauqua County does not have an OCFS approved 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?	☒	☐	☐	☐

Additional information:
CCDSS followed up with appropriate collateral sources surrounding SC's death as well as those who could speak to the safety of the SS.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
The SS did not need to be removed as a result of the fatality or for reasons unrelated.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
CCDSS offered preventive services to the family, but the family declined. The SS were referred to counseling, which they had begun at the time of this writing. The CHN's pediatrician noted a referral for Early Intervention regarding SS3, and advised of needed medical testing regarding SS1, but CCDSS did not speak with the parents regarding these referrals or offer assistance in obtaining them.

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:
Grief and bereavement services were offered to the SS. The SS began to engage in counseling services during the open investigation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Grief and bereavement services were offered to BM and BF, as well as other family members. Preventive services were also offered, but declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
Was the child acutely ill during the two weeks before death?	Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/06/2017	Sibling, Female, 5 Years	Mother, Female, 28 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Female, 5 Years	Mother, Female, 28 Years	Lack of Supervision	Indicated	
	Deceased Child, Male, 2 Years	Other Adult - Cousin, Male, 27 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Sibling, Female, 11 Years	Other Adult - Cousin, Male, 27 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Sibling, Female, 10 Years	Other Adult - Cousin, Male, 27 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Sibling, Female, 10 Years	Other Adult - Cousin, Male, 27 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 10 Years	Other Adult - Cousin, Male, 27 Years	Lack of Supervision	Indicated	
	Sibling, Female, 5 Years	Other Adult - Cousin, Male, 27 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Sibling, Female, 5 Years	Other Adult - Cousin, Male, 27 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 5 Years	Other Adult - Cousin, Male, 27 Years	Lack of Supervision	Indicated	
	Deceased Child, Male, 2 Years	Father, Male, 29 Years	Lack of Supervision	Indicated	

Sibling, Female, 11 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Female, 11 Years	Father, Male, 29 Years	Inadequate Guardianship	Indicated
Sibling, Female, 10 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Female, 10 Years	Father, Male, 29 Years	Inadequate Guardianship	Indicated
Sibling, Female, 10 Years	Father, Male, 29 Years	Lack of Supervision	Indicated
Sibling, Female, 5 Years	Father, Male, 29 Years	Inadequate Guardianship	Indicated
Sibling, Female, 5 Years	Father, Male, 29 Years	Lack of Supervision	Indicated
Deceased Child, Male, 2 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Indicated
Sibling, Female, 11 Years	Grandparent, Male, 48 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Female, 10 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Indicated
Sibling, Female, 5 Years	Grandparent, Male, 48 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Female, 5 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Indicated
Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Inadequate Guardianship	Indicated
Sibling, Female, 11 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Female, 11 Years	Mother, Female, 28 Years	Inadequate Guardianship	Indicated
Sibling, Female, 10 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Female, 10 Years	Mother, Female, 28 Years	Inadequate Guardianship	Indicated
Sibling, Female, 5 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Indicated
Deceased Child, Male, 2 Years	Other Adult - Cousin, Male, 27 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Lack of Supervision	Indicated
Sibling, Female, 11 Years	Mother, Female, 28 Years	Lack of Supervision	Indicated
Sibling, Female, 10 Years	Mother, Female, 28 Years	Lack of Supervision	Indicated

Deceased Child, Male, 2 Years	Other Adult - Cousin, Male, 27 Years	Lack of Supervision	Indicated
Sibling, Female, 11 Years	Other Adult - Cousin, Male, 27 Years	Inadequate Guardianship	Indicated
Sibling, Female, 11 Years	Other Adult - Cousin, Male, 27 Years	Lack of Supervision	Indicated
Deceased Child, Male, 2 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Indicated
Deceased Child, Male, 2 Years	Father, Male, 29 Years	Inadequate Guardianship	Indicated
Sibling, Female, 11 Years	Father, Male, 29 Years	Lack of Supervision	Indicated
Sibling, Female, 5 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Indicated
Deceased Child, Male, 2 Years	Grandparent, Male, 48 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Female, 11 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Indicated
Sibling, Female, 10 Years	Grandparent, Male, 48 Years	Inadequate Food / Clothing / Shelter	Indicated

Report Summary:
This report was received by CCDSS with concerns the parents were allowing the CHN to play outside unsupervised for 4 to 5 hours daily, during which time they walk across the street. There were concerns SS1 acted as a caregiver for the younger CHN, and on at least one occasion SC was at risk of being struck by a vehicle; SS1 ran into the road to pick him up. BM, BF, and OA were aware that SS1 was not an adequate caregiver to the CHN, but continued to allow them to be unsupervised. Lastly, there were concerns the CHN had chronic head lice, and the home was in deplorable conditions. A subsequent report was received on 9/23/17 with further concerns regarding the deplorable home environment.

Determination: Indicated | **Date of Determination:** 12/07/2017

Basis for Determination:
CCDSS completed interviews with family members and collaterals regarding the allegations in the report. The home was found to be in deplorable conditions upon receipt of the subsequent report. SS2 had ongoing medical needs and had not seen her pediatrician since January 2016. CCDSS also documented the amount of instruction that the CHN received during their homeschooling was questionable. Services were offered to the family but they declined. SC passed away during this investigation.

OCFS Review Results:
Neither the CPS history check nor 7 Day Safety Assessment were completed within their required time frames. History mentions the family moved out of state in 2016, but this was not discussed nor was an out of state CPS history check conducted. CCDSS did not follow up with the family regarding all concerns noted in the pediatric medical records.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7 Day Safety Assessment was not completed within the required time frame.

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

Action:

Within seven days of receiving a report, CCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Issue:
Review of CPS History
Summary:
CPS history was not reviewed within the required time frame, and the record did not reflect if UNF history was reviewed.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, CCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child's sibling, and, for indicated reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
Pediatric records noted concerns for the CHN, including referrals and recommendations; at his last visit, SC was underweight and behind on immunizations. CCDSS did not discuss these concerns with the parents. CCDSS did not discuss if the CHN had adult supervision at the library, or if any of the SS informed an adult SC had been ill while there.
Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:
CCDSS will conduct complete and adequate investigations that explore all concerns fully prior to case closure.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The case record reflected the family moved out of state in 2016; however, CCDSS did not explore this further or assess whether or not an out of state CPS record check needed to be conducted.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
CCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

[redacted]

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

6/2006: SM IND for LM re: SS1.
1/2008: SM UNF for LM, IG, IF/C/S re: SS2.
8/2008: SM IND for M/FTTH, IG re: SS1.
11/2009: MGM and MGF UNF for IG, PD/AM re: SS2.
4/2011: MGM IND for IG, LM, M/FTTH re: SS1.
11/2011: SM UNF for PD/AM re: SS3.
4/2014: SM and SF UNF for IF/C/S, IG, L/B/W re: SS1 and SS3.

Known CPS History Outside of NYS

It is unknown if OA had any CPS history outside of the NYS, as CCDSS did not request this information.

Preventive Services History

5/2006: FSS opened due to BM having SS1 at age 17, and being unable to adequately care for the medically frail CH. The case was closed 8/2006 after MGM obtained custody of SS1, and declined to continue services.
1/2008: FSS opened per BM's request. BM was looking to strengthen her parenting abilities due to having another medically frail CH (SS2). In 9/2008, SS2 was removed due to BM's refusal to engage in services. BM signed an admission in 3/2009. The case was closed 3/2010 after MGM obtained joint custody of SS2, along with BF.
5/2011: FSS opened after MGM and MGF failed to keep up with SS2s medical needs. The family was compliant with services, and by case closure, SS2's health had improved and there were no further concerns. The case closed in 1/2012.
1/2012: FSS opened per BM's request, as she had just given birth to SS3 and was having difficulties caring for SS2. The family was compliant with services. The case closed in 3/2012 after BM reported the family was moving out of state.
11/2012: FSS opened after BM left SS1 and SS3 unsupervised, and SS1 fell out of a two-story window causing severe injuries. The CHN were placed in the care of PGM and PGF; all parties were compliant with services. Court ordered supervision ended in 1/2014, and the CHN returned to the care of BM and BF. BM and BF moved in with the paternal grandparents, and the services case was closed.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Foster Care Placement History

In 9/2008, SS2 was removed and placed into Foster Care after BM refused to engage in services regarding SS2's health; SS2 was a medically fragile child and her needs were not being met. On 3/4/2009, BM signed an admission and court ordered services were put into place. MGM was compliant with service plan goals throughout the life of the case, and worked toward obtaining custody of SS2. On 3/16/10, SS2 was placed into Article 6 custody with MGM and the case was closed.

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