# Report Identification Number: BU-23-041

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

## Issue Date: Mar 26, 2024

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 had an open investigation or a CPS monitored services 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 | DA-District Attorney | |
| **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 | SXTF-Sex Trafficking |
| **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
**Jurisdiction:** Niagara
**Date of Death:** 11/11/2023
**Age:** 14 year(s)
**Gender:** Male
**Initial Date OCFS Notified:** 11/11/2023

### Presenting Information

An SCR report alleged the 14-year-old child was diagnosed with acute heart failure. Despite the mother and father being aware, they failed to follow through with medical treatment, including required surgery and ongoing cardiologist appointments. The child was last seen by a cardiologist in 2019. On 09/23/23, the child was admitted to the hospital for heart failure symptoms, and a viral infection. The child remained in the hospital and on 11/11/23, around 2:00 AM, he complained of abdominal pain, and became unresponsive. The child was transported to the Intensive Care Unit. Lifesaving efforts were made to no avail. At 3:30 AM, the child was pronounced dead. The parents' failure to follow through with the required medical treatment contributed to the child's death.

### Executive Summary

This report concerns the death of the 14-year-old child that occurred on 11/11/23. An SCR report was made on the same day, alleging the parents did not seek appropriate medical treatment for the child. At the time of the child's death, he resided with his parents and siblings, aged 12 days and 16 and 20 years. The children were assessed to be safe.

Niagara County Department of Social Services (NCDSS) contacted law enforcement upon receipt of the SCR report. A criminal investigation was not conducted. An autopsy was not performed. NCDSS obtained the death certificate, which listed the cause of death to be complications of congenital heart disease due to or as a consequence of congenital heart disease. The manner of death was natural.

The mother was interviewed and reported the child was hospitalized in the weeks leading up to his death. The child was planning to be discharged on 11/10/23; however, he was complaining of chest pains, dizziness and overall, he did not feel well.

NCDSS made collateral contacts with hospital staff, the pediatrician, and staff at the cardiologist's office. The child was overdue for well-child checks and had not been seen by the cardiologist since 2019. The hospital doctor reported the child complained of abdominal pain before he went unresponsive. The child was declared deceased after extensive and prolonged resuscitation efforts were unsuccessful. The collateral contacts did not have concerns for the parents' care of the siblings.

The allegations of Lack of Medical Care and DOA/Fatality were unsubstantiated. The Investigation Conclusion Narrative stated there was not a fair preponderance of evidence to support the allegations. The child was diagnosed with a heart disease in 2009. The parents sought medical attention for the child in September 2023, and he was hospitalized. The child was expected to be discharged; however, died at the hospital on 11/11/23. NCDSS noted that staff at the cardiologist's office noted the child "slipped through the cracks". The record also stated medical providers could not definitively say that the lack of follow through with medical appointments caused the death.

NCDSS completed required reports and Safety Assessments timely and accurately. Home visits were made, and the family was seen; however, the record did not reflect family members aside from the mother were interviewed. NCDSS appropriately determined and closed the investigation on 01/05/24.

**PIP Requirement**

NCDSS will submit a PIP to the Buffalo Regional Office within 30 days of the receipt of this report. The PIP will identify

action(s) the NCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, NCDSS will review the plan and revise as needed to address ongoing concerns.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

- **Was sufficient information gathered to make the decision recorded on the:**
  - **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:**
The decision to close the case was appropriate.

**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:**
Casework activity was not commensurate with case circumstances as the record did not reflect that family members aside from the mother were interviewed.

### Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Failure to Conduct a Face-to-Face Interview (Subject/Family) |
| **Summary:** | Although the mother was interviewed, the record did not reflect attempts to interview other family members who resided in the home, including the father, who was a subject of the report. |
| **Legal Reference:** | 18 NYCRR 432.2(b)(3)(ii)(a) |
| **Action:** | A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes. |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 11/11/2023 **Time of Death:** 03:30 AM

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

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

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

**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 | Male | 14 Year(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 43 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 38 Year(s) |
| Deceased Child's Household | Sibling | No Role | Female | 20 Year(s) |
| Deceased Child's Household | Sibling | No Role | Female | 16 Year(s) |
| Deceased Child's Household | Sibling | No Role | Male | 12 Day(s) |

### LDSS Response

On 11/11/23, NCDSS received the fatality report from the SCR. Within the first 24 hours of the investigation, NCDSS contacted the source of the report, completed a CPS history check, contacted law enforcement and the district attorney’s office, and spoke with hospital staff. The siblings were assessed to be safe.

The investigation revealed the child was diagnosed with congenital heart disease in 2009 and was seen by a pediatric cardiologist; however, he did not undergo surgeries that were scheduled in both 2015 and 2019. Staff at the cardiologist’s office reported the child should have been seen every 4 to 6 months for his condition and believed the child “fell through the cracks.”

NCDSS gathered information from hospital staff. The child was hospitalized in September 2023 due to respiratory symptoms and abdominal pain. The child received an echocardiogram that showed decreased heart function, and the child was in respiratory distress. The child was expected to be discharged on 11/10/23, but he complained of chest pain, so he was kept for monitoring. Medical professionals expected the child would ultimately die from his heart condition; however, his death was not expected to be imminent.

Hospital staff reported that on the day of the death, the father was visiting the child when he came out of the child's room saying that the child had a seizure. The father reported to medical staff that the child's eyes rolled back, and he stopped moving or responding. A doctor reported that the child had complained of abdominal pain, cried, and became unresponsive. Resuscitation efforts were unsuccessful, and the child was declared deceased at 3:30 AM.

A home visit was made on 12/05/23 and the family was observed. The mother was interviewed and reported that on 11/09/23, the child was preparing to be discharged from the hospital the following day. However, the child complained of chest pain, dizziness and did not feel well. The hospital completed tests which showed no findings. Hospital staff believed the child may have pulled a muscle, or that his symptoms could have been a side effect of medication. The record did not reflect attempts to interview other family members who resided in the home.

NCDSS completed required Safety Assessments and required reports timely and accurately. Services including burial assistance and grief counseling were offered to the family. The family utilized counseling services through their church. It remained unknown if burial assistance was utilized. The case was appropriately determined and closed timely.

## Official Manner and Cause of Death

**Official Manner:** Natural
**Primary Cause of Death:** From a medical cause
**Person Declaring Official Manner and Cause of Death:** Hospital physician

## Multidisciplinary Investigation/Review

**Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?** Yes

**Was the fatality referred to an OCFS approved Child Fatality Review Team?** Yes

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 066739 - Deceased Child, Male, 14 Year(s) | 066740 - Mother, Female, 38 Year(s) | DOA / Fatality | Unsubstantiated |
| 066739 - Deceased Child, Male, 14 Year(s) | 066740 - Mother, Female, 38 Year(s) | Lack of Medical Care | Unsubstantiated |
| 066739 - Deceased Child, Male, 14 Year(s) | 066741 - Father, Male, 43 Year(s) | DOA / Fatality | Unsubstantiated |
| 066739 - Deceased Child, Male, 14 Year(s) | 066741 - Father, Male, 43 Year(s) | Lack of Medical Care | 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?** | ☐ | ☒ | ☐ | ☐ |
| Family Members | ☐ | ☒ | ☐ | ☐ |
| **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 assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:** | | | | |
| **Within 24 hours?** | ☒ | ☐ | ☐ | ☐ |
| **At 7 days?** | ☒ | ☐ | ☐ | ☐ |
| **At 30 days?** | ☒ | ☐ | ☐ | ☐ |
| **Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?** | ☒ | ☐ | ☐ | ☐ |
| **Are there any safety issues that need to be referred back to the local district?** | ☐ | ☒ | ☐ | ☐ |

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

**Fatality Risk Assessment / Risk Assessment Profile**

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **Was the risk assessment/RAP adequate in this case?** | ☒ | ☐ | ☐ | ☐ |
| **During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?** | ☒ | ☐ | ☐ | ☐ |
| **Was there an adequate assessment of the family's need for services?** | ☒ | ☐ | ☐ | ☐ |
| **Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?** | ☐ | ☒ | ☐ | ☐ |
| **Were appropriate/needed services offered in this case** | ☒ | ☐ | ☐ | ☐ |

**Explain:**
Appropriate service referrals were given to the family.

## 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 as a result of information uncovered during the fatality investigation?** | ☐ | ☒ | ☐ | ☐ |

**Explain as necessary:**
No children needed to be removed.

## Legal Activity Related to the Fatality

**Was there legal activity as a result of the fatality investigation?** There was no legal activity.

## Services Provided to the Family in Response to the Fatality

| Services | Provided After Death | Offered, but Refused | Offered, Unknown if Used | Not Offered | Needed but Unavailable | N/A | CDR Lead to Referral |
|---|---|---|---|---|---|---|---|
| Bereavement counseling | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Economic support | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| Funeral arrangements | ☐ | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ |
| Housing assistance | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| Mental health services | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Foster care | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| Health care | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| Legal services | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| Family planning | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Homemaking Services** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Parenting Skills** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Domestic Violence Services** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Early Intervention** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Alcohol/Substance abuse** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Child Care** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Intensive case management** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Family or others as safety resources** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Other** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**Additional information, if necessary:**
The family utilized bereavement services provided through their church.

**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 siblings were offered grief counseling; however, the family declined the services offered by NCDSS and utilized services through their church.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
Although not accepted through NCDSS, the mother received counseling through her church.

## History Prior to the Fatality

### Child Information

**Did the child have a history of alleged child abuse/maltreatment?** 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) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 09/22/2023 | Deceased Child, Male, 14 Years | Father, Male, 42 Years | Educational Neglect | Unsubstantiated | No |
| | Deceased Child, Male, 14 Years | Father, Male, 42 Years | Inadequate Guardianship | Unsubstantiated | |
| | Deceased Child, Male, 14 Years | Father, Male, 42 Years | Lack of Medical Care | Unsubstantiated | |
| | Sibling, Female, 15 Years | Father, Male, 42 Years | Educational Neglect | Unsubstantiated | |

| | | | |
|---|---|---|---|
| Sibling, Female, 15 Years | Father, Male, 42 Years | Inadequate Guardianship | Unsubstantiated |
| Sibling, Female, 15 Years | Father, Male, 42 Years | Lack of Medical Care | Unsubstantiated |
| Deceased Child, Male, 14 Years | Mother, Female, 37 Years | Educational Neglect | Unsubstantiated |
| Deceased Child, Male, 14 Years | Mother, Female, 37 Years | Inadequate Guardianship | Unsubstantiated |
| Deceased Child, Male, 14 Years | Mother, Female, 37 Years | Lack of Medical Care | Unsubstantiated |
| Sibling, Female, 15 Years | Mother, Female, 37 Years | Educational Neglect | Unsubstantiated |
| Sibling, Female, 15 Years | Mother, Female, 37 Years | Inadequate Guardianship | Unsubstantiated |
| Sibling, Female, 15 Years | Mother, Female, 37 Years | Lack of Medical Care | Unsubstantiated |

**Report Summary:**
An SCR report alleged the child, and 15yo sibling did not attend school since February 2022. Both children were failing and falling behind academically as a result of their absences. The mother and father were aware and did not provide an explanation for the absences. A subsequent report received on 09/25/23 alleged the child was diagnosed with a heart disease at birth. The parents were aware the child needed follow up care with a cardiologist and surgeries. The child required a surgery in 2016 yet the parents did not follow through with medical recommendations. As a result, the child was hospitalized due to a decreased heart function. The lack of treatment put the child at risk of a stroke.

**Report Determination:** Unfounded | **Date of Determination:** 11/13/2023

**Basis for Determination:**
The allegations were unsubstantiated as the investigation did not reveal a fair preponderance of evidence to support them. The parents stated they enforce school attendance rules. The child was hospitalized during the investigation, and subsequently died. The sibling had trouble adjusting to the new school and said she would attend regularly.

**OCFS Review Results:**
The investigation was initiated timely, and the source was contacted. Home visits were made, and the family was interviewed. Appropriate collateral contacts were made. The 7-day Safety Assessment was completed timely.

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 09/29/2022 | Deceased Child, Male, 13 Years | Father, Male, 41 Years | Educational Neglect | Substantiated | Yes |
| | Deceased Child, Male, 13 Years | Father, Male, 41 Years | Inadequate Guardianship | Substantiated | |
| | Sibling, Female, 14 Years | Father, Male, 41 Years | Educational Neglect | Substantiated | |
| | Sibling, Female, 14 Years | Father, Male, 41 Years | Inadequate Guardianship | Substantiated | |
| | Deceased Child, Male, 13 Years | Mother, Female, 36 Years | Educational Neglect | Substantiated | |
| | Deceased Child, Male, 13 Years | Mother, Female, 36 Years | Inadequate Guardianship | Substantiated | |

| | | | | |
|---|---|---|---|---|
| | Sibling, Female, 14 Years | Mother, Female, 36 Years | Educational Neglect | Substantiated |
| | Sibling, Female, 14 Years | Mother, Female, 36 Years | Inadequate Guardianship | Substantiated |

**Report Summary:**
An SCR report alleged during the 2022-2023 school year, the then 14-year-old sibling and then 13-year-old child did not attend school. As a result, the children were failing. The parents were aware and failed to ensure the children attended school.

**Report Determination:** Indicated | **Date of Determination:** 01/18/2023

**Basis for Determination:**
The allegations of IG and EdN were substantiated against the parents. The children did not attend school during the 2022-2023 academic year. The parents avoided outreach efforts by the school. The parents provided "a number of excuses" for the absences and did not devise nor implement a plan to address the education needs.

**OCFS Review Results:**
The investigation was initiated timely, and the source was contacted. A CPS history check was documented. Home visits were made, and family members were interviewed. The parents were provided referrals for community-based interventions and Persons in Need of Supervision.

**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 completed untimely on 11/04/22, 29 days late.

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

**Action:**
NCDSS will document and approve all Safety Assessments within the required timeframes.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 01/19/2022 | Deceased Child, Male, 14 Years | Mother, Female, 36 Years | Educational Neglect | Unsubstantiated | Yes |
| | Sibling, Female, 14 Years | Mother, Female, 36 Years | Educational Neglect | Unsubstantiated | |
| | Deceased Child, Male, 14 Years | Father, Male, 41 Years | Educational Neglect | Unsubstantiated | |
| | Sibling, Female, 14 Years | Father, Male, 41 Years | Educational Neglect | Unsubstantiated | |

**Report Summary:**
An SCR report alleged the parents failed to provide adequate care for the child and older sibling. The parents registered the children for school on 10/05/21. Since then, the sibling missed 45 days of school and the child missed 35 days. The sibling did not attend school since 12/13/21, and the child did not attend since 12/21/21. The children were failing their classes and had a history of excessive absences. The parents did not intervene.

**Report Determination:** Unfounded | **Date of Determination:** 05/04/2022

**Basis for Determination:**
The allegations were unsubstantiated. The Investigation Conclusion Narrative stated the parents were concerned about a virus as the child had a heart condition that compromised his health. The parents were concerned the child or sibling would become ill, negatively affecting the child. The children utilized online instruction until the sibling struggled and had "written off" school for the year. The mother stated she would obtain medical excuses that allowed the child to learn remotely.

**OCFS Review Results:**
The investigation was initiated timely, and the source was contacted. A CPS history check was completed timely. Interviews with the family were allegation focused. The allegations were inappropriately determined. The 7-day Safety Assessment was completed timely.

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

**Issue:**
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

**Summary:**
Although family members were interviewed, the record did not reflect overall safety and risk factors were discussed with the family. The interviews were allegation focused and did not include an assessment of overall risk and safety.

**Legal Reference:**
18 NYCRR 432.1 (o)

**Action:**
NCDSS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

**Issue:**
Appropriateness of allegation determination

**Summary:**
The allegations were inappropriately determined. The record reflected the child and sibling were both failing classes and the parents did not take appropriate actions to ensure the children were provided with an education.

**Legal Reference:**
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

**Action:**
NCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Buffalo Regional Office if further guidance is needed.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 08/11/2021 | Sibling, Female, 16 Years | Mother, Female, 35 Years | Inadequate Guardianship | Unsubstantiated | Yes |
| | Sibling, Female, 16 Years | Father, Male, 40 Years | Inadequate Guardianship | Unsubstantiated | |

**Report Summary:**
An SCR report alleged the parents were in a “violent altercation” in the presence of the children. There was an incident wherein the father got into a “violent confrontation” with a person who was visiting the home. One of the children was present during the incident.

**Report Determination:** Unfounded | **Date of Determination:** 09/28/2021

**Basis for Determination:**
The allegations were unsubstantiated. The Investigation Conclusion Narrative stated that the parents denied the allegations and stated that they were “loud people” and denied fighting or arguing. The children denied the allegations and appeared safe and well cared for.

**OCFS Review Results:**
The case was initiated timely by contacting the source of the report. Interviews with the family were appropriate. A CPS history check was completed untimely. Attempts to contact relevant collaterals were not documented. The 7-day Safety Assessment was completed timely.

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

**Issue:**
Review of CPS History
**Summary:**
A CPS history check was completed untimely on 09/07/21.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(i)
**Action:**
Within 1 business day of a report, NCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, NCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

**Issue:**
Contact/Information From Reporting/Collateral Source
**Summary:**
Although the pediatrician's office was contacted as a collateral, the record did not reflect attempts to gather information from individuals who may have had information regarding family functioning or information regarding the allegations of the report.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(b)
**Action:**
NCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

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

Between 05/29/15 and 10/17/19, there were 9 investigations regarding the family. Educational Neglect was investigated 7 times, all of which were unfounded. Other allegations included Inadequate Guardianship, Inadequate Food/Clothing/Shelter, Lack of Medical Care, and Parent Drug/Alcohol Misuse. All of the allegations were unsubstantiated.

## Known CPS History Outside of NYS

There is no known CPS history outside of New York.

## 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