# Child Fatality Report

## Report Identification Number: NY-17-045

## Prepared by: New York City Regional Office

## Issue Date: Nov 14, 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 | 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:** Richmond
**Gender:** Male
**Date of Death:** 05/05/2017
**Initial Date OCFS Notified:** 05/05/2017

### Presenting Information

On 5/5/17, the two-year-old male child died while in the SM's care at the family home. The SC had a history of Asthma. Although the SC had been experiencing neck pain, he was running around and active all day. The SC was eating swedish fish candies and the SM instructed the SC to regurgitate. The neck pain continued and the SM administered a breathing treatment. After the treatment, the pain persisted and the SM called EMS. The SC was transported to Richmond University Medical Center where he was pronounced dead at 5:29 PM.

### Executive Summary

The SCR registered a report of the death of a two-year-old male on 5/5/17. The report alleged that at 4:30 pm, the SC was experiencing neck pain and the SM administered a breathing treatment. The pain persisted and the SM called 911 for medical assistance. The SC was transported to the RUMC where he died at 5:25 pm. The allegations of the report were DOA/Fatality and LMC of the SC by the SM.

On 5/5/17, the Staten Island Field Office contacted LE, ME and the Dr and confirmed the report. ACS learned that on 5/4/17, the SC and eight-year-old sibling stayed at the babysitter overnight because the SM was sick and went to the hospital. On 5/5/17, at 2:30 pm, the SM picked up the SC and eight-year-old and then the eleven-year-old from school and as they traveled home, she bought the children candy. The SC ate his candy and upon arrival to the home at 4:30 pm, he began to cough. The SC complained for his throat and the parents urged him to cough and regurgitate but nothing expelled. The parents administered a breathing treatment. The SC's condition worsened and the parents gave him another medication. He began to wheeze and sweat; the SM told the BF to call 911 as she initiated CPR. Ten minutes later he called back 911. EMS responded and transported the SC to the hospital where he died.

While at the hospital, the SM told the Dr that her four-year-old daughter died eleven-years ago on this exact date, also with complications from the same pre-existing medical condition. ACS learned that the SCR had registered a report on 5/5/06 with allegations of DOA/Fatality and IG of the child by the parents. The parents reported they administered medication via nebulizer; soon after, the child went into respiratory arrest and died. The investigation revealed that the toxicology report indicated no medication was found in the child's body and her airway was swollen. The autopsy report listed the cause of that child's death was Bronchial Asthma and the manner was Natural. The allegations were unsubstantiated.

On 5/6/17, the ME reported the SC's lungs were typical for a person with asthma and contained candy particles. The ME's final report is pending. ACS documented that LE reported no inconsistencies in the parents or the siblings accounts.The Dr reported no signs of abuse or neglect was found on the SC.

ACS interviewed all subjects and collaterals. The parents and two SSs reported similar details leading up to the incident. The adult sibling and her one-year-old daughter were not at home when the incident occurred. The home had appropriate sleep accommodations and food for the family. The SF reported he resides at a separate location is not the father of the first deceased child.

ACS learned from the children's pediatrician who had been providing care to the family since 2007 that the SC and the eleven-year-old SS were prescribed medications for their medical conditions and were referred to Specialist. The medical specialist disclosed that the SS had severe food allergies; the SM was consistent with following the recommendations and

keeping the children's medical appointments.

The babysitter, school staff and neighbors had no concerns with the care the SM provided to the children. The school staff was aware of the past and current circumstances;the SS was being monitored closely.

The medical specialist confirmed the SC and the eleven-year-old had been treated for pre-existing medical conditions and that the SC was last seen on 4/14/17; he was well. The SS was seen weekly.

The babysitter, school staff and neighbors had no concerns with the care the SM provided to the children. The school staff was aware of the family's history, the incident and the SS's medical condition and are monitoring them closely.

ACS referred the family to the appropriate services and the family engaged and had positive results.

ACS has not yet made a determination.

## 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?** N/A
- **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?** N/A

**Explain:**
ACS has not yet made a determination of the allegations of this report.

**Was the decision to close the case appropriate?** N/A

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

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

**Explain:**
ACS has not yet made a determination of the allegations.

## 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:** 05/05/2017 **Time of Death:** 05:25 PM

**Time of fatal incident, if different than time of death:** 04:30 PM

**County where fatality incident occurred:** Richmond
**Was 911 or local emergency number called?** Yes
**Time of Call:** 04:32 PM
**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?** Yes - Caregiver 1
**At time of incident supervisor was:** Not 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 | Alleged Victim | | 2 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 43 Year(s) |
| Deceased Child's Household | Other Child - Adult sister's child | No Role | Female | 1 Year(s) |
| Deceased Child's Household | Other Deceased Child - child died in 2006 | Alleged Victim | Female | 4 Year(s) |
| Deceased Child's Household | Sibling | No Role | Male | 8 Year(s) |
| Deceased Child's Household | Sibling | No Role | Female | 18 Year(s) |

## LDSS Response

On 5/5/17, the SCR registered a report regarding the death of a two-year-old male. The allegations of the report were DOA/Fatality and IG of the SC by the SM.

On 5/5/17, the ACS Specialist visited the Richmond University Medical Center (RUMC) and received information from EMS, Dr, ME and LE that confirmed the report. EMS reported they received two calls for assistance at 4:32 pm and 4:41 pm. EMS responded to the case address at 4:48 pm and arrived at RUMC at 5:07 pm. The Dr observed no evidence of trauma and pronounced the SC dead at 5:25 PM on 5/5/17.

The ME's preliminary report stated that the SC experienced an acute asthma attack. The material found in his stomach and throat was consistent with the report narrative. There was no obstruction of his airway and no signs of an allergic reaction. LE reported similar details to those given to ACS.

ACS visited the home and interviewed the parents and siblings. ACS interviewed the adult sibling and assessed the safety of her one-year-old daughter as they were not home at the time of the incident. The BF reported he resides at a separate location and was visiting at the time of the incident. There were no inconsistencies in the parents or the SS's details.

The SM stated that on 5/5/17, she picked up the SC and the SS from the babysitter and the older SS from school. On their way home, the SM purchased candy for the children. The SC ate "Swedish Fish". They arrived home at 4:30 pm. The SC had finished his candy when he began to cough. The parents administered medication; however, the cough persisted and the SC complained for his throat. The parents assumed candy was stuck in his throat and coached him to cough, to no avail. The parents continued the treatment but the SC began to breathe heavily. He was instructed to raise his arms so as to clear his airway. The SC began wheezing and sweating profusely, the parents removed his shirt and wiped him with a wet cloth. After the fifteen-minute treatment, the parents gave the SC a different medication with a cup of water. The SC laid on his pillow and as the SM massaged his neck, his breathing exacerbated. The SM then instructed the BF to call 911 and he did so twice. The SM explained that she initiated CPR until EMS arrive and the SC was conscious.

The SM reported that on 5/5/06, her four-year-old daughter died after she had been wheezing and was given a treatment. A report was registered by the SCR; it was alleged that the parents overmedicated the child which contributed to her death. Note that the BF of the now SC is not the father of the deceased four-year-old. At that time, the physician reported that the child was found with her airway swollen. The autopsy report listed the cause of death was Bronchial Asthma and the manner was Natural. The allegations were unfounded.

The SM reported that due to breathing difficulties, the SC and the eleven-year-old SS had been hospitalized two and four times, respectively. In light of this information, ACS encouraged the SM to enroll the SS into the New York City Asthma Program and she complied. The ACS Specialist referred the family to other appropriate services. ACS reported the home had appropriate sleep accommodations and food supply.

On 5/6/17, the babysitter told ACS the SC and eight-year-old SS stayed with her from 5/4/17 until the SM picked them up at 2:30 pm on 5/5/17. The SC was coughing as usual, but playful.

On 5/7/17, the children's pediatrician, who had been providing service to the family since 2007 had last seen the SC on 4/14/17, he was well. All SS's immunizations were current.

The medical specialist reported the SC had severe allergies to multiple common food items. Another specialist reported the eleven-year-old SS is seen weekly, the eight-year-old had no conditions.

There are concerns regarding how well the SC's condition was managed and the severity of the condition.

ACS has not made a determination.

**Official Manner and Cause of Death**

**Official Manner:** Pending
**Primary Cause of Death:** From a medical cause
**Person Declaring Official Manner and Cause of Death:** Medical Examiner

## Multidisciplinary Investigation/Review

**Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?**No
**Comments:** There is no Multidisciplinary Team in New York City. The ACS investigation adhered to previously approved protocols for joint investigation.

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?**No
**Comments:** There is no approved OCFS Child Fatality Review in the New York City region.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 041401 - Deceased Child, , 2 Yrs | 041402 - Mother, Female, 43 Year(s) | Inadequate Guardianship | Pending |
| 041401 - Deceased Child, , 2 Yrs | 041402 - Mother, Female, 43 Year(s) | DOA / Fatality | Pending |
| 041406 - Other Deceased Child - child died in 2006, Female, 4 Year(s) | 041402 - Mother, Female, 43 Year(s) | DOA / Fatality | Unsubstantiated |
| 041406 - Other Deceased Child - child died in 2006, Female, 4 Year(s) | 041402 - Mother, Female, 43 Year(s) | Inadequate Guardianship | 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?** | ☒ | ☐ | ☐ | ☐ |
| **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?** | ☒ | ☐ | ☐ | ☐ |
| **Did the investigation adhere to established protocols for a joint investigation?** | ☒ | ☐ | ☐ | ☐ |

| | | | | |
|---|---|---|---|---|
| **Was there timely entry of progress notes and other required documentation?** | ☒ | ☐ | ☐ | ☐ |

**Additional information:**
Records pertaining to the child's death were reviewed via the CONNECTIONS database.

## 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:**<br>Base on the ACS case progress noted, no removal was necessary. | | | | |

## 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 | Needed but 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:**<br>The SM was receptive to services offered. | | | | | | | |

**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 family was referred for bereavement counseling. The SM was reminded to closely monitor the eleven-year-old sibling's severe asthma condition. The SS's were enrolled in summer camp and the SM received parenting skill training provided under the auspices of the Beacon Preventive Services Program.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
The family was referred for bereavement counseling.

## History Prior to the Fatality

### Child Information

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

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 10/10/2013 | Sibling, Female, 14 Years | Mother, Female, 40 Years | Lack of Supervision | Unfounded | No |
| | Sibling, Female, 14 Years | Mother, Female, 40 Years | Educational Neglect | Unfounded | |
| | Sibling, Female, 14 Years | Mother, Female, 40 Years | Inadequate Guardianship | Unfounded | |

**Report Summary:**
The report narrative stated that the now eighteen-year-old child had ran away and had not been attending school. The child had been failing. The SM had not returned communication from the school.

**Determination:** Unfounded | **Date of Determination:** 12/02/2013

**Basis for Determination:**
ACS' case documentation reflected the SM filed a missing person notification on behalf of the child. The child entered voluntary placement. The SC continued to AWOL and the SM filed a Person In Need of Supervision warrant and the child was remanded to a non-secured facility. On 10/23/13, the child was placed in a secured placement. ACS unfounded the allegations and transferred the case to another unit for monitoring and return to court. There were no concerns for the siblings as their needs were being met. The SM had taken the necessary steps to manage the child. The SC was reunified with her mother on 6/25/14. The FSS stage was opened on 8/15/14 to 12/01/14.

**OCFS Review Results:**
The determination was appropriate.

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 06/17/2013 | Sibling, Female, 14 Years | Mother, Female, 39 Years | Lack of Medical Care | Unfounded | No |
| | Sibling, Female, 14 Years | Mother, Female, 39 Years | Educational Neglect | Unfounded | |
| | Sibling, Female, 14 Years | Mother, Female, 39 Years | Inadequate Guardianship | Unfounded | |

**Report Summary:**
The narrative alleged that the now eighteen-year-old child missed over thirty days of school and was failing as a result. The narrative alleged that the SM was aware of child's behavior and that she needed counseling and the SM did not allow the mental health intervention.

**Determination:** Unfounded | **Date of Determination:** 07/12/2013

**Basis for Determination:**
ACS' case documentation reflected the child continued to be truant and exhibited violent behaviors resulting in suspension from school. The documentation reflected the SM's efforts were at least minimum; however futile, the child was not receptive. The SM filed a Person In Need of Supervision in family court in order to receive assist with the child's behavior. ACS documented no credible evidence was found to support the concerns of IG, LMC and EN of the child by the SM.

**OCFS Review Results:**
The appropriate actions were taken.

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 03/12/2013 | Sibling, Female, 14 Years | Mother, Female, 39 Years | Educational Neglect | Unfounded | No |

**Report Summary:**
The now eighteen-year-old child had been absent thirty-six-days and late 67 times from school and as a result, the child was failing.

**Determination:** Unfounded | **Date of Determination:** 05/03/2013

**Basis for Determination:**
ACS investigation revealed that the child was a chronic runaway who refused to attend school or followed house rules. ACS found that the SM made reasonable efforts to ensure the child attended school and the SM maintained communication with school staff. As a result of ACS' intervention, the child's attendance improved. ACS gave the SM material about possible interventions should the child fail to attend school again. ACS maintained that the two younger siblings appeared very well cared for and they had been attending school. The SM declined services and the case was closed.

**OCFS Review Results:**
ACS' actions were appropriate.

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

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

On 12/27/2001, the SCR registered a report with allegations of IG and LBW of the eight-month-old infant by the babysitter (SM). The report alleged the infant sustained a bruise on his face as the result of a fall that occurred while in the care of the SM's nine-year-old child. The investigation revealed the SM admitted that she left the infant asleep with the nine-year-old child. The nine-year-old reported the infant fell and the SM denied stating she was holding the infant in her arms as she attempted to open the stroller and the infant's face leaned on the coat button and left a mark on his face. ACS

substantiated the allegation of LBW and unsubstantiated the allegation of IG.

On 5/5/2006, the SCR registered a report alleging DOA/Fatality and IG of the then four-year-old child by the SM. The autopsy report listed the cause of the child's death as Bronchial Asthma and the manner of death as natural. ACS appropriately unsubstantiated all allegations citing no evidence to indicate that the SM's actions or behavior caused or contributed to the child's death and there was no evidence indicating neglect or criminality by the SM. The SM and the then three surviving siblings received bereavement services. The documentation noted the SM appeared to be very responsible, caring and appropriate with the surviving siblings.

## Known CPS History Outside of NYS

There is no known CPS History outside of NYS.

## Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

## Legal History Within Three Years Prior to the Fatality

**Was there any legal activity within three years prior to the fatality investigation?** There was no legal activity

## Recommended Action(s)

**Are there any recommended actions for local or state administrative or policy changes?** ☐Yes ☒No

**Are there any recommended prevention activities resulting from the review?** ☐Yes ☒No