Child Fatality Report

Report Identification Number: SV-23-067

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

Issue Date: May 28, 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: Orange
Date of Death: 12/23/2023
Age: 6 year(s)
Gender: Male
Initial Date OCFS Notified: 12/26/2023

Presenting Information

Orange County Department of Social Services (OCDSS) completed an OCFS-7065 Agency Reporting Form on 12/26/23, after learning of the 6-year-old subject child's death. There was an open services case at the time of the death.

Executive Summary

On 12/24/23, Orange County Department of Social Services (OCDSS) was notified by the hospital that the 6-year-old male subject child passed away on 12/23/23. OCDSS had an open CPS investigation, which began on 11/27/23, due to concerns regarding supervision. At the time of his death, the subject child resided with the father. The subject child's mother resided at her respective residence out of state. The 10-year-old surviving sibling split her time between both the father and her respective mother's residences. OCDSS immediately assessed the safety of the surviving sibling and determined she was safe in the care of her parents.

OCDSS spoke with the hospital and learned when the subject child arrived at the hospital, he was positive for a bacterial infection and had a very low red and white blood cell count. The subject child appeared to be declining and was on his way to a CT scan when he went into cardiac arrest. He could not be revived and was pronounced deceased at 8:21PM.

On 3/15/23, OCDSS received the final autopsy report from the medical examiner. The subject child's cause of death was Streptococcus Pyogeues- (Group A) meningitis in 6-year-old child with leukocytopenia and pancytopenia of unknown origin and the manner of death was natural. Law enforcement spoke with the medical examiner and the father and had no concerns for the subject child.

The father reported to OCDSS that he was approved for burial assistance. OCDSS coordinated with a therapist to assist the father and surviving sibling with grief counseling and the father had an appointment scheduled. The allegations from the open CPS investigation were unsubstantiated. It was determined the cause of death was not linked to negligence on the parent's behalf.

PIP Requirement
For citations identified in historical cases, OCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS 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:**

- **Safety assessment due at the time of determination?** 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:
There was no SCR report regarding the fatality; therefore, the completion of safety assessment tools was not required. Regarding the open investigation, there was sufficient information gathered to make the determination that the allegation of LS be unfounded.

Was the decision to close the case appropriate?	Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	Yes
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:
Case documentation did not reflect any reasons for the case to remain open with services. Caseworker activity was commensurate with case circumstances.

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: 12/23/2023 **Time of Death:** 08:21 PM

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

County where fatality incident occurred:	Orange
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: Admitted into the hospital.		

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	6 Year(s)
Deceased Child's Household	Father	No Role	Male	38 Year(s)
Deceased Child's Household	Father's Partner	No Role	Female	40 Year(s)
Other Household 1	Mother	No Role	Female	35 Year(s)
Other Household 2	Other Adult - SS's BM	No Role	Female	30 Year(s)
Other Household 2	Sibling	No Role	Female	10 Year(s)
Other Household 3	Aunt/Uncle	No Role	Female	44 Year(s)

LDSS Response

OCDSS began gathering information regarding the SC's death on 12/24/23, after being notified of his passing by the hospital. OCDSS coordinated their efforts with LE and communicated with the ME. OCDSS immediately assessed the surviving sibling to be safe in the care of her parents.

OCDSS had several interactions with the BF in which he was distraught and blamed himself for the SC's death. He reported feeling guilty for not bringing the SC to the hospital sooner.

OCDSS spoke with both hospitals and learned the BF brought the SC to the hospital due to him having a high fever, vomiting and diarrhea, that had been occurring for two days. They arrived at the first hospital around 12:07PM. The SC was transferred to the second hospital when his temperature dropped too low. The SC was incoherent and unable to answer questions. The BF reported to the hospital that he did give the SC medication for his fever. As the SC continued to decline, it was decided a CT scan would be done to determine if there was any internal bleeding. On the way to the CT scan, the SC went into cardiac arrest and was unable to be revived. He was pronounced dead at 8:21PM.

LE had communicated with the ME's office and determined there were no signs of abuse or neglect. LE met with the BF twice for interviews and had no concerns. The BF provided LE with a timeline and stated the SC had been sick for two days with a fever. On the third day, the SC vomited and did not want to eat. The BF reported the SC did not look right so he brought him to the hospital. The BF explained that due to the low red and white blood cell count the SC was rushed to another hospital. LE planned to close their case after receiving the final autopsy report.

Hospital staff had concerns because the BF could not provide the SCs medical history or the pediatrician. There is no documentation that OCDSS inquired with the BF about this. There are no documented attempts to speak with the SC or 10yo SS's pediatrician. During the open case, the BF reported the SS had the same bacterial infection the SC had before passing away. OCDSS did not follow up to determine if the SS was seen by a medical provider. OCDSS collaborated with LE and hospital staff and collected the final autopsy report from the ME. OCDSS gathered pertinent information to determine the SC died from a medical condition and had no concerns for the BF.

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: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: OCDSS has an OCFS approved CFRT.

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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
School	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
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?				

Explain:
There was no SCR report regarding the SC's death; therefore, there were no allegations regarding the fatality and the completion of safety assessment tools were not required.

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

Explain as necessary:
There was no SCR report regarding the death; therefore, there were no allegations regarding the fatality and the completion of safety assessment tools was not required.

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	☐	☐	☐	☐	☐	☒	☐

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:

OCDSS coordinated with a mental health counselor who was then able to coordinate with the BF. The BF setup at least one home visit with the mental health counselor to meet with the SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

The BF reported that he was approved for burial assistance. OCDSS coordinated with a mental health counselor for the BF and SS. The BF followed through with the services.

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	Alleged	Alleged	Allegation(s)	Allegation	Compliance

SCR Report	Victim(s)	Perpetrator(s)		Outcome	Issue(s)
11/27/2023	Deceased Child, Male, 6 Years	Father, Male, 38 Years	Lack of Supervision	Unsubstantiated	Yes

Report Summary:
An SCR report was received on 11/27/23, that alleged the BF left the SC in an unfinished basement for 15 minutes unsupervised. The SC had special needs and required constant supervision. It was unknown if the SC was injured. On 12/24/23, additional information was received that stated, on 12/23/23, the SC was brought to the hospital for a high fever, vomiting and body aches. While at the hospital he went into cardiac arrest and passed away at 8:21PM.

Report Determination: Unfounded **Date of Determination:** 03/27/2024

Basis for Determination:
The allegation of LS against the BF regarding the SC was unsubstantiated. There was insufficient evidence to support the allegation alleging the SC was alone in an unfinished basement for 15 minutes without any adult supervision. The BF lives on the 2nd floor and has no basement. The CHN were interviewed and reported feeling safe with the BF. The paternal aunt reported that the SC was not in her basement either.

OCFS Review Results:
OCDSS began their investigation within 24 hours, contacted the source, and completed a CPS history review. The BF and the PS were interviewed, and the home was assessed to be safe. OCDSS asked the CHN if they felt safe but did not ask about the allegations or safety and risk questions. The SSs BM was interviewed about the BF only. The SC's BM did not return OCDSS's phone calls. OCDSS contacted the paternal aunt to address the allegations and confirm the BF's account of events. Case notes were entered in a timely manner. The case appropriately remained open until the SCs final autopsy was received.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
When the BF reported the SS had the same viral infection the SC had prior to passing away OCDSS did not follow up with the parents or pediatrician to determine if medical attention was sought.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. OCDSS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/18/2023	Sibling, Female, 10 Years	Father, Male, 38 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 10 Years	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Male, 6 Years	Father, Male, 38 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 6 Years	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 10 Years	Father, Male, 38	Internal Injuries	Unsubstantiated	

	Years		
Sibling, Female, 10 Years	Father, Male, 38 Years	Sexual Abuse	Unsubstantiated

Report Summary:
An SCR report was received that alleged the BF had been molesting the 10yo SS for several months, was abusing substances, and was a felon. A subsequent report came in alleging the BF was sexually abusing the SS and as a result she was bleeding from her genital area.

Report Determination: Unfounded | **Date of Determination:** 12/10/2023

Basis for Determination:
OCDSS unsubstantiated the allegations of IG and PD/AM against the BF regarding the SC and the 10yo SS and unsubstantiated the allegations of II and SA against the BF regarding the SS as there was no fair preponderance of evidence. Both children were interviewed and didn't disclose any abuse or neglect.

OCFS Review Results:
OCDSS began their investigation within 24 hours, contacted the source, and completed a CPS history review. OCDSS completed a forensic interview with the 10yo SS and interviewed the SC, the BF and the PS. The home and the CHN were assessed for safety and there were no concerns. Both BMs were spoken to about the allegations but not fully interviewed. OCDSS remained in contact with the BF throughout the investigation and monitored the CHNs transition into his care. OCDSS did not contact all appropriate collateral sources, such as, school staff and medical providers. The investigation was overdue, and the majority of the notes were entered late.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
Multiple progress notes were not entered timely during the investigation, 32 out of 55 were entered at least over a month late.

Legal Reference:
18 NYCRR 428.5

Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
There were missed opportunities to gather collateral information from medical providers. Concerns were brought to OCDSS attention regarding schooling; however, the concerns were not followed up on and no schools were contacted.

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

Action:
OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

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

Summary:
OCDSS contacted both BMs over the phone to explain there was a SCR report. OCDSS did not interview either of them. The SC's BM was asked if she had concerns but not asked about the allegations. The 10yo SS's BM was asked about the allegations only.

Legal Reference:
18 NYCRR 432.1 (o)
Action:
OCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/04/2022	Sibling, Female, 9 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 9 Years	Mother, Female, 29 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The SCR report stated that on 10/1/22, the then 9yo SS's BM, hit the SS in the face with a belt. As a result, she sustained a laceration to her lip. There was a history of physical violence that was increasing.

Report Determination: Unfounded | **Date of Determination:** 05/15/2023

Basis for Determination:
OCDSS did not write a determination in the investigation conclusion. It is unclear why the investigation was unfounded.

OCFS Review Results:
OCDSS began their investigation within 24 hours, the source was contacted, and a CPS history review was complete. The CHN were seen, the parents were interviewed, and the homes were assessed for safety. The investigation was not completed timely and was closed four and a half months late with more than half of the progress notes overdue and without a determination being written.

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

Issue:
Appropriateness of allegation determination
Summary:
OCDSS did not justify Unsub the allegation. No determination was written. The SS reported the BM had been hitting her with a belt on her arms and legs. The SCs lip appeared bitten and scabbed. The BM admitted to hitting the SS with a belt and stated the SS bit her own lip when she was hit. OCDSS did not check the SC's legs. There appeared to be enough evidence for the report to be substantiated.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
OCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the (whichever) Regional Office if further guidance is needed.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
A court note from 10/7/22, stated the BM was to be supervised while with the SS. On 2/23/23, the SS was alone with the BM. OCDSS did not address this or confirm they were able to be unsupervised. The BF reported the judge ordered the CHN remain in his care. OCDSS did not follow up to confirm this with family court. 33 out of 59 notes were overdue. The case was open for 7 months.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

OCDSS must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

Issue:

Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:

School staff reported the SS needed an evaluation. OCDSS did not speak with the pediatrician regarding possible delays, did not follow up with the BM regarding paperwork, and did not collect documentation. Police reports indicated at least five violent incidents with the BM that OCDSS did not inquire about. The SS reported the BM hit the other child on his bottom but they did not check his bottom.

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(c)

Action:

OCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/12/2021	Sibling, Female, 7 Years	Other Adult - SS's BM, Female, 27 Years	Educational Neglect	Far-Closed	Yes
	Sibling, Female, 7 Years	Father, Male, 35 Years	Educational Neglect	Far-Closed	

Report Summary:

The SCR report alleged the then 7yo SS had 72 absences from school for the 2020-2021 school year. The 7yo SS's BM and BF were aware but failing to ensure the SS attended school or participated and completed assignments on a regular basis. As a result, the SS was failing.

OCFS Review Results:

OCDSS began their investigation within 24 hours, attempted to contact the source and completed a CPS history review. The home was safety assessed and the CHN were observed. The 7yo SS's BM was interviewed, and allegations were addressed. There was no documentation of the BF being interviewed or allegations being addressed. The investigation was not completed timely. The case was closed with the concerns worsening, without services being offered or a legal consult being completed. There was information in a letter to the Family Court judge that was not reflected in the case notes.

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

Issue:

FAR-Overall Completeness/Adequacy of Family Assessment Response

Summary:

Although the concerns worsened, they were not addressed with the BM, school documentation was not obtained, no services were offered and legal was not consulted. A COI was sent to family court with information that was not documented in the case notes. The case was 10 weeks overdue, 7 out of 21 progress notes were late, and no casework was done for two months.

Legal Reference:

18 NYCRR 432.13 (a)(1-4)

Action:

OCDSS will comply with OCFS regulations pertaining to required activities in a FAR case.

Issue:

FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible

Summary:

OCDSS did not interview either father or speak with them about the report. The SS's BF was spoken to over the phone about an unrelated matter, but allegations and safety and risk questions were never addressed. The OC's BF was never added to the case and no attempts were made to speak with him.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)

Action:

Family assessment response workers must work in partnership with the families participating in a family assessment. Workers should be transparent with families regarding all actions they take. To the extent feasible, child protective service workers should include all family members in discussions, including CHN who are old enough, and other persons who the family would like to include.

Issue:

FAR-Failure to Engage the Family

Summary:

The SS was spoken with but not interviewed about allegations regarding school, grades or attendance or other safety and risk related questions in the FLAG. The BM was interviewed but not all FLAG questions were explored. The FLAG was also completed late, on the day of case closing.

Legal Reference:

18 NYCRR 432.13 (e)(2)(iii)

Action:

Children will be engaged in discussions whenever possible in an effort to elicit key information surrounding safety and risk. Discussions with all family members will include relevant safety-related questions.

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

A CPS investigation was open from 7/8/20 through 9/23/20. SS's BM was unfounded for allegations of EN, IF/C/S, IG and PD/AM regarding the SS and unfounded for allegations of IG and PD/AM regarding OC. OA unfounded for allegations of IG and PD/AM regarding the SS and OC.

A CPS investigation was open from 8/5/19 through 9/11/19. The SS's BM and OA were unfounded for IG against SS and OC.

A FAR Investigation was open from 5/31/18 through 6/20/18. Alleged concerns for IG and PD/AM against the PS and two other adults regarding OC. There were no concerns.

A FAR Investigation was open from 9/26/17 through 1/3/18. Alleged concerns for IG against the PS and OA regarding OC. There were no concerns.

A FAR Investigation was open from 1/10/17 through 3/16/17. The BF petitioned the court for custody of the SS. A court ordered investigation was completed.

Preventive Services History

A Preventive Services Case was open from 9/26/13 through 11/7/13. The SS's BM was homeless. The case was closed when the family found an apartment.

A Preventive Services Case was open from 6/11/13 through 7/11/13. The SS's BM needed housing. The case was closed due to her relocating out of the area.

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