# Child Fatality Report

## Report Identification Number: SY-17-008

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

## Issue Date: Aug 21, 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 | | |
| **Contacts** | | |
| LE-Law Enforcement | CW-Case Worker | CP-Case Planner |
| Dr.-Doctor | ME-Medical Examiner | EMS-Emergency Medical Services |
| DC-Day Care | FD-Fire Department | BM-Biological Mother |
| CPR-Cardiopulmonary Resuscitation | | |
| **Allegations** | | |
| FX-Fractures | II-Internal Injuries | L/B/W-Lacerations/Bruises/Welts |
| S/D/S-Swelling/Dislocation/Sprains | C/T/S-Choking/Twisting/Shaking | B/S-Burns/Scalding |
| P/Nx-Poisoning/ Noxious Substance | XCP-Excessive Corporal Punishment | PD/AM-Parent's Drug Alcohol Misuse |
| CD/A-Child's Drug/Alcohol Use | LMC-Lack of Medical Care | EdN-Educational Neglect |
| EN-Emotional Neglect | SA-Sexual Abuse | M/FTTH-Malnutrition/Failure-to-thrive |
| IF/C/S-Inadequate Food/ Clothing/ Shelter | IG-Inadequate Guardianship | LS-Lack of Supervision |
| Ab-Abandonment | OTH/COI-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 |

## Case Information

**Report Type:** Child Deceased
**Age:** 5 year(s)
**Jurisdiction:** St. Lawrence
**Gender:** Male
**Date of Death:** 02/22/2017
**Initial Date OCFS Notified:** 03/10/2017

### Presenting Information

On 3/10/2017 an SCR report was received by St. Lawrence County Department of Social Services (SLCDSS) regarding the death of the 5-year-old male SC. The report alleged that on 2/22/2017 the SF left the home, leaving the SC in the care of the PGM and unrelated home member (UHM), despite being aware they were intoxicated and were not appropriate caregivers for the SC. The SC was in an upstairs bedroom when a fire broke out due to a space heater at the top of the stairs. The PGM and UHM were too intoxicated to respond to the fire and they went outside with other adults who were also present and intoxicated and left the SC in the home. The PGM and UHM continued to consume alcohol outside while waiting for emergency vehicles to arrive. After the fire department managed the fire, EMS removed the SC from the home. The SC was taken to Massena Memorial Hospital where he was pronounced deceased. When the SF arrived at the hospital he was intoxicated. The role of the BM was unknown.

### Executive Summary

On 3/10/2017 SLCDSS received an SCR report with allegations of DOA/Fatality and IG against SF, PGM and PGM's boyfriend (UHM) and PD/AM against PGM and UHM regarding the 5-year-old SC. BM reported there was a Family Court order in which she and SF shared joint custody of the SC, with the SC alternating weeks with each parent. BM resided with SC's step father, MGGF and MA. SC visited with SF at the PGM's home, where she resided with UHM. BM and SF had no other children and there were no other children residing in either home.

Through interviews conducted by LE and SLCDSS it was learned that BM dropped the SC off at PGM's home on the morning of 2/22/2017 for a visit. PGM and UHM stated they had the SC all day and that SF did not come to the home at all. That night, UHM was in the kitchen of the home drinking alcohol and smoking marijuana with two other adult males (OA1 and OA2). PGM was in the living room with the SC and she was also drinking alcohol. OA1 said he saw the SC playing with a lighter and trying to set the carpet on fire. He took the lighter away from the SC and put the lighter in his pocket. He was unable to recall any additional details due to being so intoxicated. The SC fell asleep on the couch between 9:30 and 9:45 PM. UHM carried the SC up to a bedroom on the second floor of the home and put him to bed. OA1 said he "passed out" on the couch and when he woke up he saw that the house was on fire. UHM said he was in the kitchen with OA2 when OA1 came into the kitchen saying the house was on fire. OA2 said he drank alcohol with OA1, then he fell asleep on the couch and awoke to a fire in the home. PGM yelled for them to put buckets of water on the fire and she called 911 around 9:56 PM. The fire was in the hallway at the top of the stairs, outside the bedroom that the SC was in. UHM, OA1 and OA2 put water on the fire and UHM swatted at the fire with his hands. PGM said she yelled the SC's name and the adults said they were not able to get to the SC. LE and the fire department arrived. The SF smelled like alcohol when he arrived and had to held back from entering the home.

The first responding LE officer entered the SC's bedroom and found him sitting up on the bed slumped over and unresponsive. He carried the SC out of the home wrapped in a blanket and EMTs transported the SC to the hospital. Resuscitative efforts were unsuccessful and the SC was pronounced deceased by the ER physician at 10:38 PM.

SF would not meet with SLCDSS face to face so he was initially interviewed on the phone. He reported that he was with the SC all day and he was the one who put the SC to bed the night of the incident. He said after putting the SC to bed he went out to dinner with his girlfriend. He received a phone call that the house was on fire so he returned to the home.

An autopsy was performed and the cause of death was determined to be lethal intoxication of carbon monoxide and the manner of death was accidental. An investigation was conducted into the cause of the fire, and although the exact cause had yet to be determined, an electrical cause was ruled out and the fire was deemed to be non-accidental. The investigation revealed that the bedroom door was likely locked from the outside when the fire started. The LE investigation remained open and criminal charges had yet to be filed. SLCDSS IND the report against the PGM and UHM and closed it as there were no SS.

OCFS review of this fatality investigation revealed issues regarding timeliness and adequacy of documentation of safety assessments. In response, SLCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) the Regional Office has taken, or will take, to address the cited issue. For citations where a PIP is currently implemented, SLCDSS will review the plan and revise as needed to further 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:**
SLCDSS made an appropriate assessment of safety and appropriately determined all allegations.

**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:**
SLCDSS made an appropriate assessment of safety and appropriately determined all allegations. The case was closed as there are no SS.

### Required Actions Related to the Fatality

**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 due by 3/17/2017 and was not completed until 4/3/2017. |
| **Legal Reference:** | SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c) |

| | |
|---|---|
| **Action:** | SLCDSS will complete a 7-day safety assessment within 7 days of receipt of the report. |
| | |
| **Issue:** | Adequacy of Documentation of Safety Assessments |
| **Summary:** | The 24-hour and 7-day safety assessments inaccurately reflected safety factors for the SC. Since there were no SS, both assessments should have reflected no safety factors. |
| **Legal Reference:** | 18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b) |
| **Action:** | SLCDSS will accurately reflect safety factors in 24-hour and 7-day safety assessments. |
| | |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 02/22/2017 **Time of Death:** 10:38 PM

**Time of fatal incident, if different than time of death:** 09:56 PM

**County where fatality incident occurred:** St. Lawrence
**Was 911 or local emergency number called?** Yes
**Time of Call:** 09:56 PM
**Did EMS to respond to the scene?** Yes
**At time of incident leading to death, had child used alcohol or drugs?** No
**Child's activity at time of incident:**

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

**Did child have supervision at time of incident leading to death?** Yes
**Is the caretaker listed in the Household Composition?** No
**At time of incident supervisor was:**

- ☐ Drug Impaired
- ☒ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☐ Asleep
- ☐ Impaired by illness
- ☐ Other:

**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 | 5 Year(s) |
| Deceased Child's Household | Mother | No Role | Female | 24 Year(s) |

| | | | | |
|---|---|---|---|---|
| Other Household 1 | Father | Alleged Perpetrator | Male | 30 Year(s) |
| Other Household 2 | Grandparent | Alleged Perpetrator | Female | 54 Year(s) |
| Other Household 2 | Unrelated Home Member | Alleged Perpetrator | Male | 54 Year(s) |

## LDSS Response

Upon receiving the SCR report SLCDSS contacted the BM and LE for more information. It was determined that there were no SS and there were no children residing in either the BM's home or the PGM's home. SLCDSS worked diligently with LE to locate the PGM, UHM and SF, since they had relocated after the fire. As each adult was located, they were interviewed by SLCDSS. Each adult gave different information about the timeline of events. The SF refused to meet with SLCDSS face to face. He was initially interviewed over the phone and said he was with the SC all day on 2/22/2017 and then put the SC to bed and went out for dinner. SLCDSS later located SF at jail, where he was incarcerated for a probation violation. During this interview SF would not speak about the incident, but said the PGM and UHM were there only adults in the home and were sober when he left the home. He said did not know UHM was going to drink and that he wished he never left SC with PGM that night. The UHM said the BM dropped the SC off to him and PGM on the morning of 2/22/2017. The PGM and UHM said the BF was not with the SC at all that day and they put him to bed. The PGM admitted to drinking alcohol and stated that OA1 and OA2 were in the home drinking alcohol and smoking marijuana with the UHM. UHM confirmed he was drinking alcohol and smoking marijuana with OA1 and OA2. OA1 was located and interviewed. He said he saw the SC playing with a lighter and took it away from him, although additional details were unable to be gathered about this incident. The PGM and UHM did not report seeing this incident. OA2 was later located and spoken to on the phone. He confirmed that he drank alcohol with OA1. He said he then fell asleep on the couch and awoke to the fire in the home. The details of the fire were consistent amongst the adults in that once the fire started they attempted to put the fire out with water, called 911 and were unable to get to the SC in the upstairs bedroom.

Several home visits were conducted at the BM's home and the BM, MA and MGGF were interviewed. The BM said the SC was having behavioral difficulties and recently burned himself with a lighter. The BM stated that she dropped the SC off with the BF on 2/21/2017 and asked him to keep the SC until 2/23/2017. She said after the fire she found out that the smoke detectors at the PGM's home were old, had no batteries and were not working. The MGGF and MA had no concerns for the SC. None of the adults interviewed were aware of how the fire started.

Due to the inconsistent statements and the unclear cause of the fire, a fire investigator was brought in to determine the cause of the fire. This investigation determined that the fire was non-accidental, an electrical cause was ruled out and it was determined that the bedroom door where the SC was discovered was likely locked from the outside. It was confirmed there were no batteries in the smoke detectors in the home. As a result of these findings and the fact that the adults in the home had consumed alcohol and/or marijuana and were impaired, SLCDSS substantiated the allegations against the PGM and UHM. SLCDSS unsubstantiated the allegations against the SF as the PGM and UHM were the only adults in the home and were reported to be sober when he left the SC at the home.

SLCDSS reviewed CPS history for all the adults, contacted the source and completed the 24-hour and 30-day fatality reports on time. SLCDSS inaccurately reflected safety factors for the SC in the 24-hour and 7-day safety assessments, although they should have reflected no safety factors were present as there were no SS. The 7-day safety assessment was completed 17 days past the due date. Medical records were received and reviewed for the SC, which revealed no concerns for the SC's health, other than an unrelated condition for which he was prescribed medication. SLCDSS referred the adults for bereavement counseling and the BM engaged in counseling.

## Official Manner and Cause of Death

**Official Manner:** Accident
**Primary Cause of Death:** From an injury - external cause

**Person Declaring Official Manner and Cause of Death:** Coroner

## Multidisciplinary Investigation/Review

**Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?**No

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?**No

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 039601 - Deceased Child, Male, 5 Yrs | 039688 - Grandparent, Female, 54 Year(s) | DOA / Fatality | Substantiated |
| 039601 - Deceased Child, Male, 5 Yrs | 039701 - Unrelated Home Member, Male, 54 Year(s) | Parents Drug / Alcohol Misuse | Substantiated |
| 039601 - Deceased Child, Male, 5 Yrs | 039701 - Unrelated Home Member, Male, 54 Year(s) | Inadequate Guardianship | Substantiated |
| 039601 - Deceased Child, Male, 5 Yrs | 039701 - Unrelated Home Member, Male, 54 Year(s) | DOA / Fatality | Substantiated |
| 039601 - Deceased Child, Male, 5 Yrs | 039688 - Grandparent, Female, 54 Year(s) | Inadequate Guardianship | Substantiated |
| 039601 - Deceased Child, Male, 5 Yrs | 039687 - Father, Male, 30 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 039601 - Deceased Child, Male, 5 Yrs | 039688 - Grandparent, Female, 54 Year(s) | Parents Drug / Alcohol Misuse | Substantiated |
| 039601 - Deceased Child, Male, 5 Yrs | 039687 - Father, Male, 30 Year(s) | DOA / Fatality | Unsubstantiated |

## CPS Fatality Casework/Investigative Activities

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **All children observed?** | ☐ | ☐ | ☒ | ☐ |
| **When appropriate, children were interviewed?** | ☐ | ☐ | ☒ | ☐ |
| **Alleged subject(s) interviewed face-to-face?** | ☒ | ☐ | ☐ | ☐ |
| **All 'other persons named' interviewed face-to-face?** | ☐ | ☐ | ☒ | ☐ |
| **Contact with source?** | ☒ | ☐ | ☐ | ☐ |
| **All appropriate Collaterals contacted?** | ☐ | ☒ | ☐ | ☐ |
| Emergency Room Personnel | ☐ | ☒ | ☐ | ☐ |
| **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:**
SLCDSS did not speak to or obtain records from the ER.

## Fatality Safety Assessment Activities

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Were there any surviving siblings or other children in the household?** | ☐ | ☒ | ☐ | ☐ |

## Legal Activity Related to the Fatality

**Was there legal activity as a result of the fatality investigation?**
☒Family Court ☐Criminal Court ☐Order of Protection

| **Family Court Petition Type:** Other Family Court (Including Article 6 Custody/Guardianship | | |
|---|---|---|
| **Date Filed:** | **Fact Finding Description:** | **Disposition Description:** |
| | There was not a fact finding | There was not a disposition |
| **Respondent:** | None | |
| **Comments:** | The BM said she filed a violation petition in Family Court against the SF after the SC's death. She said he violated the Article 6 custody order when he drank alcohol around the SC. SLCDSS received copies of the Family Court Article 6 order and violation petition filed by the BM. The Family Court judge dismissed the violation petition. | |

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

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

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

**Additional information, if necessary:**
The BM enrolled herself in bereavement counseling and SLCDSS referred the SF to counseling. The SF, PGM and UHM would benefit from an alcohol/substance abuse evaluation.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** No
**Explain:**
The SF was not cooperative with the investigation and would not meet with SLCDSS until the end of the investigation. Counseling services were offered at that time. No immediate services were offered to the BM.

## History Prior to the Fatality

### Child Information

**Did the child have a history of alleged child abuse/maltreatment?** Yes
**Was there an open CPS case with this child at the time of death?** No
**Was the child ever placed outside of the home prior to the death?** No
**Were there any siblings ever placed outside of the home prior to this child's death?** N/A
**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) |
|---|---|---|---|---|---|
| 08/02/2016 | Deceased Child, Male, 4 Years | Mother, Female, 23 Years | Inadequate Guardianship | Far-Closed | Yes |

**Report Summary:**
CPS report alleged the BM failed to ensure dangerous substances were not in the SC's reach despite the SC having

accessed poisonous substances 3 other times in the past. As a result, the SC was found holding prescription medication which was left out in a container which was not child proof. The SC was not injured.

**OCFS Review Results:**
The case was appropriately screened FAR. BM, MA, SC and MGGF were spoken to and the SC was assessed to be safe. SF was not spoken to, but an NOE was sent and attempts were made. The FLAG was completed on 10/19/2016, more than a month late. All but 2 progress notes were entered on 10/19/2016; therefore; most of the progress notes were not entered contemporaneously. SLCDSS referred the BM to speak to the school about additional services for the SC to deal with his anger and aggression toward other children. The case was closed when the BM obtained a locked box for the medication and the BM denied the need for any additional services.

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

**Issue:**
Timely/Adequate Case Recording/Progress Notes
**Summary:**
Most of the progress notes were not entered contemporaneously, some of which were more than 2 months past the event date.
**Legal Reference:**
18 NYCRR 428.5
**Action:**
SLCDSS will enter progress notes contemporaneously.

**Issue:**
FAR-Timely/Adequate Family-Led Assessment Guide
**Summary:**
The Family Led Assessment Guide (FLAG) is due no more than 30 days following receipt of the report. The FLAG was completed on 10/19/2016.
**Legal Reference:**
18 NYCRR 432.13 (e)(2)(iii)-(v)
**Action:**
SLCDSS will complete the FLAG no more than 30 days following receipt of a report that is tracked FAR.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 03/05/2015 | Deceased Child, Male, 3 Years | Mother, Female, 22 Years | Other | Unfounded | No |
| | Deceased Child, Male, 3 Years | Father, Male, 27 Years | Other | Unfounded | |

**Report Summary:**
SCR report received alleged that St. Lawrence County Family Court Judge directed CPS to conduct a court ordered investigation.

**Determination:** Unfounded **Date of Determination:** 06/09/2015

**Basis for Determination:**
SLCDSS unsubstantiated the allegation of Other against the BM and SF regarding the SC. The BM and SF were seeking custody of the SC. The BF admitted the PA babysat the SC when she first got out of jail for a drug related offense, although denied that the PA lived with BF or was under the influence of drugs when she babysat the SC. The PA was no reportedly longer babysitting the SC. The SC was observed to be safe and Head Start was working with the SC in both parent's homes weekly. Both BM and SF's homes were observed to have no safety hazards or concerns. The parents were awarded joint custody with the SC visiting each parent on alternating weeks.

**OCFS Review Results:**

SLCDSS appropriately unsubstantiated the allegations. SLCDSS interviewed the BM, SF, SC, MA and MGGF. SLCDSS attempted to interview the PA but were unsuccessful. Appropriate collateral contacts were made with the PGM, MGM, Head Start, LE and SC's pediatrician. The safety assessments and RAP were completed accurately and on time. There was sufficient supervisory consultation documented throughout the case.

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

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

SCR report 02/14/2002 substantiated against PGM for EdN regarding SF as a child. SF had excessive unexcused absences from school and was failing several classes. PGM did not communicate with the school.

SCR report 09/26/1996 substantiated against PGM for Other (IG) regarding her daughter and SF as a child. PGM was intoxicated while caring for her children. PGM refused services, case closed.

SCR report 07/23/1992 substantiated against PGM for Other regarding her daughter and SF as a child. No additional information available.

## Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

## Required Action(s)

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

## 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