Child Fatality Report

Report Identification Number: SY-18-042

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

Issue Date: Feb 26, 2019

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: 7 year(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 09/24/2018
Initial Date OCFS Notified: 09/25/2018

Presenting Information

An SCR report alleged on or about 9/24/18, the 7yo child expired in his sleep due to mother, the mother's boyfriend, and the maternal grandmother failing to obtain proper medical care for the child and failing to ensure that the child received proper nutrition. The adults were aware the child was not maintaining calories and was losing weight to the point that he weighed roughly 25lbs, his eyes were sunken in, and his sternum and ribcage were visible. Additionally, the child suffered from several medical conditions including a severe form of epilepsy. The caretakers failed to seek appropriate medical care for the child despite his known medical conditions. The child had not been seen by a medical professional since 2017. There was not adequate food in the home for the 5yo sibling and the home was unfurnished. The family did not have any viable resources.

Executive Summary

On 9/24/18, Onondaga County Department of Social Services (OCDSS) received a report from the SCR about the death of a 7-year-old child (SC) that occurred on the same date. The child resided with his mother, the mother's boyfriend, maternal grandmother, and two surviving siblings ages 5 and 3. The biological father resided outside of the home and had infrequent contact with the child. The family had a Preventive Services case that had been opened since 6/29/18. Services were being offered to the family as the mother and CHN were living in a shelter, struggling to find permanent housing, and SM was failing to meet the CHN's medical needs.

Through interviews with the mother, grandmother, and mother's boyfriend, it was learned that the SC was a medically fragile child who was diagnosed with multiple medical conditions. It was learned that, on 9/24/18, at approximately 3:30AM, the SC's feeding tube beeped indicating the SC had finished eating, and the mother turned it off. When she awoke at 7:30AM she found the SC was cold to the touch and unresponsive. The mother's boyfriend called 911.

OCDSS made extensive efforts to interview first responders and diligently documented all casework. OCDSS spoke with familial collateral contacts and medical personnel. OCDSS obtained and reviewed all pertinent medical records.

The SC had not been seen by a doctor since 2015. The medical examiner reported, "medical neglect likely played a role in the SC's passing, as he was not being followed closely by a physician." The medical examiner further explained, "though the death was natural it is possible for people with the syndrome to live into adulthood with the proper medical care." The last time the child was seen by a medical professional was in 2015, at that time it was recommended that he follow up every 3 months for routine changing of his G-Tube and monitoring his weight and feeding schedule. OCDSS made a recommendation for the CHN to be seen by a medical professional, the mother did not follow through with the recommendations.

OCDSS indicated the allegations of DOA/Fatality against the mother regarding the SC. Medical professionals reported the SC was a medically neglected child that was severely underweight for his age. OCDSS determined the family needed ongoing support to meet the CHN's medical and educational needs and continued working with them through Preventive Services. An article 10 neglect petition was filed on behalf of the surviving siblings due to the mother's failure to comply with recommendations from the department regarding the CHN's medical needs. The petition was pending in Family Court at the time of this writing.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
OCDSS determined that additional services were needed at the time they closed their investigation. Concerns arose during the investigation that required the department to file a petition as an effort to protect the surviving siblings. The neglect petition was pending in Family Court at the time of this writing.

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:
OCDSS was appropriate in determining their investigation and filing a petition in Family Court with regard to the surviving siblings. OCDSS continued working with the family on a Preventive Services case following determining the investigation.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/24/2018 **Time of Death:** Unknown

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 07:30 AM
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
How long before incident was the child last seen by caretaker? 3 Hours
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	Male	7 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	45 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	5 Year(s)
Other Household 1	Father	No Role	Male	27 Year(s)
Other Household 1	Sibling	Alleged Victim	Female	3 Year(s)
Other Household 2	Father	No Role	Male	30 Year(s)

LDSS Response

OCDSS received the report from the SCR on 9/24/18 and coordinated with LE, reviewed the CPS history, and notified the DA's office about the death. Throughout the investigation, collateral contacts were made with family members, first responders, medical professionals, the Preventive Services caseworker, and the worker from Salvation Army.

On 9/24/18, OCDSS interviewed the SM and her boyfriend at their home. SM reported she, her boyfriend, and the siblings all share a bed. The home was observed to be sparsely furnished with just two box spring beds pushed together. OCDSS documented the food supply in the home was limited. According to the SM, the SC's feeding tube alarmed at 3:30AM, indicating his feeding was complete. She turned off the device at that time. The SM said the next time she saw the SC was at 7:30AM. SC was cold to the touch and had foam coming out of his mouth. SM said that in the 24 hours leading up to the death, nothing was out of the norm. SM reported the SC ate four times, 7AM, 12PM, 5PM, and 10PM before laying down to bed. It was unknown if this was an appropriate feeding schedule for the SC or whether the amount of food he was

getting was appropriate. SM reported being concerned about the SC's recent weight loss, but did not seek any medical attention. SM said SC had several seizures a day and she would "hold him" until he came out of the seizures. At the time child was four, he was receiving daily injections for his seizures, but SM believed the medication made the seizures worse and stopped medicating him. The SC was seen by Upstate Neurology in October of 2012 and was prescribed medication at that time for his medical condition. Neurology requested a follow up in December of 2012, but SC was not seen again until January of 2015 due to a respiratory infection. SC was not seen after October of 2015 despite recommendations for every three month follow up.

OCDSS assessed the 5YO sibling at the SM's home. The child had no obvious issues. SM reported she would not vaccinate the siblings because she thought vaccinations caused the SC's medical conditions. It was unknown how many years since the child had been seen medically. The 3YO sibling was staying with her father following the fatality and that child was observed by a Cortland County caseworker. The child was observed to be free from observable concerns. Both the Cortland County caseworker and OCDSS advised the father to have the child seen by a medical professional due to ongoing concerns for lack of medical treatment.

Both siblings were seen by a medical professional following the recommendation of OCDSS. The siblings had not received immunizations and were put on a schedule to get them up to date. The 5YO sibling had serious tooth decay and was referred to a specialist for oral surgery.

OCDSS added allegations of Inadequate Guardianship for the 3yo sibling and Educational Neglect and Lack of Medical Care for the 5yo sibling due to the mother and her partner failing to meet the CH's medical and educational needs. OCDSS determined the biological father of the CHN did not have a significant role and no allegations were added or indicated against him. OCDSS accurately determined the allegations after conducting a thorough investigation. The safety and risk assessments were fitting to the case circumstances. The mother and her partner followed through with the recommendation for medical care and OCDSS continued to assess the CHN's treatment and the mother's follow through throughout the remainder of the investigation. LE determined there was no criminality and closed their case. OCDSS provided the SM bereavement information and funeral assistance, but it was unknown if the mother utilized the resources. Services were already in place and the Preventive Services case continued. OCDSS filed an Article 10 Neglect, which was pending in Family Court at the time of this writing.

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 investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047777 - Deceased Child, Male, 7 Yrs	047780 - Grandparent, Female, 45 Year(s)	Inadequate Guardianship	Unsubstantiated

047777 - Deceased Child, Male, 7 Yrs	047779 - Mother's Partner, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
047777 - Deceased Child, Male, 7 Yrs	047780 - Grandparent, Female, 45 Year(s)	Lack of Medical Care	Unsubstantiated
047777 - Deceased Child, Male, 7 Yrs	047780 - Grandparent, Female, 45 Year(s)	Malnutrition / Failure to Thrive	Unsubstantiated
047777 - Deceased Child, Male, 7 Yrs	047780 - Grandparent, Female, 45 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047777 - Deceased Child, Male, 7 Yrs	047779 - Mother's Partner, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
047777 - Deceased Child, Male, 7 Yrs	047779 - Mother's Partner, Male, 37 Year(s)	Malnutrition / Failure to Thrive	Unsubstantiated
047777 - Deceased Child, Male, 7 Yrs	047779 - Mother's Partner, Male, 37 Year(s)	Lack of Medical Care	Unsubstantiated
047777 - Deceased Child, Male, 7 Yrs	047779 - Mother's Partner, Male, 37 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047777 - Deceased Child, Male, 7 Yrs	047780 - Grandparent, Female, 45 Year(s)	DOA / Fatality	Unsubstantiated
047781 - Sibling, Male, 5 Year(s)	047779 - Mother's Partner, Male, 37 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047781 - Sibling, Male, 5 Year(s)	047779 - Mother's Partner, Male, 37 Year(s)	Educational Neglect	Substantiated
047781 - Sibling, Male, 5 Year(s)	047780 - Grandparent, Female, 45 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047781 - Sibling, Male, 5 Year(s)	047779 - Mother's Partner, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
047781 - Sibling, Male, 5 Year(s)	047780 - Grandparent, Female, 45 Year(s)	Inadequate Guardianship	Unsubstantiated
049153 - Sibling, Female, 3 Year(s)	047779 - Mother's Partner, Male, 37 Year(s)	Inadequate Guardianship	Substantiated

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

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
As a result of the investigation, an article 10 neglect petition was filed regarding the surviving siblings. Though court was adjourned, the judge ordered that the children were to attend all medical appointments and school.

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?	☐	☒	☐	☐

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: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	049171 Mother Female 26 Year(s)	
Comments:	A neglect petition was filed regarding the surviving siblings and there has yet to be a disposition or fact finding. Court was scheduled for 2/8/19, but the record does not reflect the outcome of the court appearance.	

Services Provided to the Family in Response to the Fatality

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

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

Additional information, if necessary:
The family was offered information regarding funeral assistance. The mother was provided referrals for bereavement counseling for herself and the surviving siblings and was also given information for assistance through the Child Advocacy Center with regard to Christmas gift assistance.

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 mother received referrals for grief counseling for the surviving siblings as well as a brochure from OCDSS titled, "Talking to Children About Death." The family was already receiving a multitude of services through the Salvation Army and OCDSS Preventive Services for assistance with meeting the CHN's medical and educational needs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Immediately following the fatality, assistance was offered to the SM with regard to appropriate medical care for the SS, contacting the school to set up appropriate education, and offering assistance with finding transportation and utilizing resources.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	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)	Allegation Outcome	Compliance Issue(s)

12/13/2017	Deceased Child, Male, 7 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 7 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 7 Years	Grandparent, Female, 46 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 7 Years	Grandparent, Female, 46 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The report alleged that the SC was disabled and tube fed. SC was nonverbal and had seizures. The child resided with the mother and maternal grandmother. SC was not being fed properly and was hungry and underweight. SM and MGM were heavy smokers around SC and he was inhaling the cigarette smoke. SC's teeth were severely decayed and both SM and MGM were aware and failed to seek treatment.

Report Determination: Unfounded | **Date of Determination:** 08/03/2018

Basis for Determination:
OCDSS based their determination on lack of sufficient evidence to substantiate the allegations. OCDSS was in the home and observed adequate food. SM agreed to preventive services to work on getting the CHN in to see a doctor as well as to get the CHN registered for school.

OCFS Review Results:
OCDSS made diligent efforts to engage the mother and offered necessary services related to the children's medical and educational needs. OCDSS contacted many collateral contacts in order to gain knowledge about the family dynamics and to coordinate services. OCDSS closed the investigation without seeing the 3YO sibling who had regular and consistent contact with the mother in her home. OCDSS closed their investigation prior to confirming the CHN were seen by a doctor.

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

Issue:
Adequacy of Child Protective Services casework contacts

Summary:
OCDSS did not see or interview the 3YO surviving sibling who had regular and consistent contact with the mother, in her home.

Legal Reference:
432.2(b)(4)(vi)

Action:
OCDSS is required to obtain the name, age, and condition of other children in the home. OCDSS will add all appropriate household members to open investigations. OCDSS will see and interview the subject child(ren) and every other child in the household prior to closing the investigation.

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

Summary:
During the course of the investigation it was learned that none of the CHN in the home had received regular and preventive medical treatment. The SC was a medically fragile child and had not been seen by a doctor since 2015, despite recommendations documented that he receive follow-up ever 3 months for G-tube changing and weight monitoring. Legal was not consulted and allegations were not added.

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)	Allegation Outcome	Compliance Issue(s)
11/28/2016	Deceased Child, Male, 7 Years	Grandparent, Female, 46 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes
	Sibling, Female, 3 Years	Grandparent, Female, 46 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 5 Years	Grandparent, Female, 46 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Male, 7 Years	Mother, Female, 26 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 3 Years	Grandparent, Female, 46 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 3 Years	Mother, Female, 26 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 5 Years	Mother, Female, 26 Years	Lack of Supervision	Substantiated	
	Deceased Child, Male, 7 Years	Grandparent, Female, 46 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 5 Years	Grandparent, Female, 46 Years	Lack of Supervision	Substantiated	
	Deceased Child, Male, 7 Years	Other Adult - Unrelated Home Member, Male, 63 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 3 Years	Other Adult - Unrelated Home Member, Male, 63 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 5 Years	Other Adult - Unrelated Home Member, Male, 63 Years	Lack of Supervision	Substantiated	

Report Summary:
The maternal grandmother was home alone with the children who, at the time of the investigation, were five, three, and two. She was left home to supervise while impaired on opioids. While impaired, she was not able to provide adequate supervision for them. The mother and unrelated home member were aware, but continued to allow the children to be home alone with the grandmother.

Report Determination: Indicated **Date of Determination:** 04/12/2017

Basis for Determination:
OCDSS determined that there was some credible evidence that the mother and unrelated home member did not provide the CHN with adequate supervision when they allowed the MGM to supervise the CHN. It was determined that the medically fragile SC was being left home with the maternal grandmother on a daily basis. OCDSS observed the MGM to be under the influence of a substance during unannounced visits around the CHN. Concerns arose during the investigation regarding medical neglect, but those allegations were not added nor were they addressed in the investigation determination.

OCFS Review Results:
A 7-day safety assessment was not completed until 5 months after the receipt of the report. The children were only seen twice during the 6 months the investigation was open. The Risk Assessment Profile was scored that the mother and grandmother had appropriate expectations for all the CHN; however, both the mother and grandmother did not provide

adequate supervision for the CHN. The mother and PS allowed the grandmother to supervise the CHN regularly knowing the grandmother was abusing substances. OCDSS acknowledged the CHN were not receiving necessary medical attention, but did not add or IND allegations or seek legal consult.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP was scored that the mother and grandmother had developmentally appropriate expectations of all CHN; however, she placed the CHN at significant risk by allowing the grandmother, who had a known substance abuse problem, to regularly care for the CHN. During the INV, MGM overdosed.
Legal Reference:
18 NYCRR 432.2(d)
Action:
OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-Day Safety Assessment was not completed until 130 days after the receipt of the report.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
OCDSS will complete all safety assessments in the amount of time required and if any child is assessed to be unsafe, OCDSS will undertake immediate and appropriate controlling interventions to protect the child(ren).

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
Interviews were not completed in a timely fashion with the subjects and children. The family was initially seen on 11/29/16 and no further contact was made until 4/5/17 despite serious allegations regarding the caretaker's substance abuse while caring for the children. Ultimately, the allegations were indicated, but there was no follow up during the investigation to monitor the CHN's supervision.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
OCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the length of the investigation.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
Information was received during the course of the investigation that the CHN were not being seen for medical appointments and the SC was a medically fragile child with the last medical apt being 10/22/15. Records reflect SC needed to be seen every three months, but this concern was not addressed or remediated.
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)	Allegation Outcome	Compliance Issue(s)
12/21/2015	Deceased Child, Male, 7 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 7 Years	Mother, Female, 25 Years	Lack of Medical Care	Substantiated	

Report Summary:
At the time of the surviving sibling's birth, the mother had a history of heroin, cocaine and methadone. The child was placed in the NICU due to withdrawal symptoms. The mother refused to allow a visiting nurse and did not appear for the child's medical appointment on 12/21/15. The child was recommended for immunizations, but the mother refused. The mother was not responding to medical personnel despite their numerous attempts.

Report Determination: Unfounded **Date of Determination:** 10/26/2016

Basis for Determination:
OCDSS unfounded the allegations of Inadequate Guardianship and Parent's Drug and Alcohol Misuse due to the mother engaging and showing compliance with substance abuse treatment.

OCFS Review Results:
OCDSS did not document a timely review of CPS history. OCDSS did not appropriately interview and engage all subjects and persons on the report. A 7-day safety assessment was not completed until 10 months into the investigation. The RAP was not completed accurately as it failed to address SM's history of domestic violence and MGM's history and ongoing substance abuse. OCDSS closed the case and did not offer services despite a High risk rating and concerns for the ongoing medical neglect in the home. OCDSS learned that the CHN in the home were not receiving appropriate medical care, but did not address the concerns or seek legal consultation as a result.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-day safety assessment was not completed until 10 months after the receipt of the report. The safety assessment was not an accurate reflection of what was occurring within the first 7 days as it was not completed until the case was ready for closure.

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

Action:
OCDSS will complete all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised within the required timeframe.

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP was scored that the SM did not have a history of DV or substance abuse, but SM noted having a history of DV and received a referral for DV services from OCDSS. SM also had a history of substance abuse and was in a methadone maintenance program. MGM was listed as a secondary caretaker and it was not documented that she had a history of substance abuse despite her overdose during the case.

Legal Reference:
18 NYCRR 432.2(d)

Action:
OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements in the Risk Assessment Profile.

Issue:
Review of CPS History
Summary:
A review of CPS history was not completed until 11 months into the investigation. A progress note was entered for a completed CPS history check on 11/30/16.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within one business day, LDSS will review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded reports where the current report involves a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report. The history check should be documented in progress notes accordingly

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
OCDSS had the investigation open for over a year and there was no documentation of casework between 4/20/16 and 11/09/16. There was no contact made with the family between 3/28/16 and 11/29/16 despite concerns that the SC was documented to be medically fragile and not receiving medical care.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
OCDSS will review and adhere to regulations regarding casework practice in general. OCDSS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
OCDSS entered all notes nearly 6-10 months after their event date.
Legal Reference:
18 NYCRR 428.5
Action:
All progress notes will be entered as close as possible to their event dates.

Issue:
Failure to provide notice of report
Summary:
OCDSS did not notify the family participants of the report until nearly a year after the onset of the report. Notices were given to the family on 12/2/16 when the report was received 12/5/15.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:

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

Summary:

Information was received during the course of the investigation that the CHN were not receiving regular and preventive medical treatment. The SC was documented in the case record as well as a case that was being investigated concurrently to be medically neglected and not receiving necessary treatment, but those concerns were not addressed and there was no documentation of legal consult.

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)	Allegation Outcome	Compliance Issue(s)
08/25/2015	Deceased Child, Male, 7 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 7 Years	Mother, Female, 26 Years	Lack of Medical Care	Substantiated	

Report Summary:

The SC was severely developmentally delayed and non verbal. Child had a G-tube and a seizure disorder. The mother had a history of failing to provide the child with medical care. The child could not eat orally due to aspiration problems. The child was only able to eat a specific formula. The mother was failing to follow through with routine appointments and no showed for all appointments since March 2015. The child needed to be seen and weighed. Child was at a high risk of seizures and not receiving the seizure medication.

Report Determination: Indicated | **Date of Determination:** 12/02/2016

Basis for Determination:

OCDSS indicated the allegations due to the mother not following through with routine medical treatment, though she did bring the child for emergency medical care when needed. OCDSS determined that there was not sufficient evidence to file a petition because the mother was bringing the child to emergent care when necessary.

OCFS Review Results:

OCDSS did not complete a timely review of CPS history. OCDSS did not appropriately interview and engage all subjects and persons on the report. A 7-day safety assessment was not completed until 2 months into the investigation. The RAP was not completed accurately as it failed to address SM's history of domestic violence and MGM's history and ongoing substance abuse.

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day safety assessment was not completed until two months after the receipt of the report.

Legal Reference:

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

Action:

OCDSS will complete all safety assessments in the amount of time required.

Issue:

Overall Completeness and Adequacy of Investigations

Summary:
OCDSS had the investigation open for over a year and there was no documentation that casework took place between 4/20/16 and 11/9/16. There was no contact made with the family between 3/28/16 and 11/29/16 despite documented concerns that the SC was medically fragile and in need of emergency medical care.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
OCDSS will review and adhere to regulations regarding FAR practice and casework practice in general. OCDSS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
OCDSS entered more than half of the progress notes between 6-10 months after their event date.
Legal Reference:
18 NYCRR 428.5
Action:
All progress notes will be entered as close as possible to their event date.

Issue:
Failure to provide notice of report
Summary:
OCDSS did not notify the members of the case composition, including subjects of the report, until nearly a year after the onset of the report. Notices were given to the family on 12/2/16 when the report was received on 12/5/15.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

[redacted]

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

5/10/13: UNF and referred to community based services for IG and PDAM against SM regarding the SC and SS. Report concerned SM using drugs while pregnant for the SS. There was no credible evidence to support the allegations as SM tested negative for substances at the doctor.

2/25/15:UNF and referred to community based services. Report alleged SM was not ensuring SC was receiving proper medical attention for his serious medical issues. The investigation revealed that SM was appropriate in following recommendations from medical staff.

8/25/15: IND against the SM for IG and LMED regarding the SC. SM was not appropriate in following up with medical treatment for the medically fragile SC. The SM was not ensuring the SC was having regular weigh-ins, which were recommended by the CH's DR. There was no documentation of whether the child was losing or gaining weight as he was not attending scheduled appointments.

Known CPS History Outside of NYS

There is no known history outside of the state of New York.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 06/28/2018

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The current FASP was due on 1/24/19 and had not been launched at the time of this writing.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☐	☒	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: Preventive Services were provided by OCDSS as well as a caseworker from the Salvation Army who was providing ongoing support to the family.				

Required Action(s)

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

Issue:	Timeliness of completion of FASP
Summary:	The current FASP was overdue and had not yet been launched at the time of this writing. The FASP due date was 1/24/19.
Legal Reference:	18 NYCRR428.3(f)
Action:	OCDSS will complete timely and accurate FASPS.

Preventive Services History

A Preventive Services case was opened on 06/29/18, due to the mother's request for support, which remained open at the time of this writing. The mother and children were residing in an emergency family shelter, and needed support to see the educational, housing, and medical needs of the family. The eldest children were not enrolled in school and the SC had serious medical needs that were not being met. OCDSS supported the mother in making phone calls to schedule appointments and monitored whether the appointments were being kept, which they were not. OCDSS corresponded with the CHN's school to gather what information was needed to enroll the child and relayed this information to the mother. OCDSS worked with staff at the emergency family shelter to see that the family's needs were being met and assisted with transportation when needed.

An FSI was opened on 5/28/13 for SM who was under 21 at the time and went into Cortland County Department of Social Services for preventive services requesting support with parenting her two young children. After several failed attempts to contact the SM, the FSI case was closed.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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