Child Fatality Report

Report Identification Number: SY-19-039

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

Issue Date: Jan 16, 2020

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: 17 year(s)
Jurisdiction: Oneida
Gender: Female
Date of Death: 07/14/2019
Initial Date OCFS Notified: 07/18/2019

Presenting Information

An SCR report was received, which alleged the 17-year-old subject child had severe mental health issues which led to her being institutionalized an unknown number of times. The teenager had a history of meeting older men online and having inappropriate relationships with them. The mother was aware of the teenagers behavior and that she was in need of strict adult supervision. Despite that knowledge, on 7/13/19, the mother allowed the teenager to go to a concert in New York City alone with a 22-year-old man, whom the teenager met online. On 7/14/19, before 8AM, the teenager and the 22-year-old returned to Utica. An argument ensued between the two and the man stabbed and cut the teenager in the neck with a knife, causing her death. The mother's failure to provide appropriate supervision for the teenager led to her death.

Executive Summary

This report concerns the death of the 17-year-old subject child. The family had an open Preventive Services case at the time of the death, due to the 17-year-old's ongoing behavioral issues and mental health concerns. The teenager had a history of meeting older men on the internet and engaging in risky behaviors. Previously, the teenager was in Foster Care placement due to her behaviors. After learning of the child's death during a routine home visit, Oneida County Department of Social Services (OCDSS) gathered supplemental information from collaterals to learn the circumstances of the death and completed the 7065 form. On 7/30/19, OCDSS received a report from the SCR about the death of the teenager, which occurred on 7/14/19. Concerns alleged the mother failed to provide the necessary supervision required to keep the 17-year-old safe. At the time of the fatality, there was a surviving sibling and 3 unrelated children living in the home.

The teenager had been receiving aftercare placement prevention services from OCDSS as well as Kids Oneida, a contract agency. The teenager was placed in a residential treatment facility on 7/18/18, due to her impulsive and risky behaviors including, running away, meeting older men on the internet, and using illicit drugs. On 2/13/19, the teenager was discharged from the placement agency to her mother's care with a multitude of aftercare services.

Through interviews, it was learned the 17-year-old went to a concert in New York City with a 22-year-old male friend. There was controversy over whether the two were involved in an intimate relationship. The 22-year-old drove the 17-year-old back to Utica after the concert and an argument allegedly ensued. During the argument, the man stabbed the teenager and cut her throat, which ultimately led to her death. The man then posted the pictures on a social media site where the two had met. Due to the graphic nature of the photos being posted publicly, calls immediately started coming into 911 from concerned onlookers.

Throughout the investigation, OCDSS made extensive efforts to interview each first responder and diligently documented all casework. OCDSS spoke with all familial collateral contacts and medical personnel. OCDSS requested and reviewed all pertinent medical records for the child and her sibling and submitted said records to OCFS for review. OCDSS assessed the safety of all the children residing in the home.

At the time of this writing, the autopsy report had not yet been completed. The 22-year-old man was charged with second-degree murder and entered a plea of not guilty. The criminal case was ongoing and the man was being held without bail until his trial.

OCDSS had not yet closed the investigation at the time of this writing. The investigation remained open pending the

autopsy report. OCDSS was providing services to the family for the sibling and other children residing in the home. A multitude of community based services were also provided to the family.

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?** Unable to Determine
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
At the time of this writing the investigation remained open.

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:
At the time of this writing, the investigation remained open. Additionally, the Preventive Services case remained open for ongoing support and services.

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: 07/14/2019 **Time of Death:** Unknown

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

County where fatality incident occurred: Oneida
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
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? No - Not needed given developmental age or circumstances

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	Female	17
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Other Adult - Other Adult 2	No Role	Male	30 Year(s)
Deceased Child's Household	Other Adult - Other Adult	No Role	Female	30 Year(s)
Deceased Child's Household	Other Child - Child of Other Adults	No Role	Male	10 Year(s)
Deceased Child's Household	Other Child - Child of Other Adults	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	15 Year(s)
Other Household 1	Father	No Role	Male	37 Year(s)

LDSS Response

OCDSS received the report from the SCR on 7/30/19, regarding the death of the 17-year-old child that occurred on 7/14/19. OCDSS coordinated with LE, reviewed the CPS history, and notified the DA's office about the death. Throughout the investigation, collateral contacts were made with the source of the report, personal collaterals for the family, first responders, and various service providers.

Through interviews with the mother, it was learned the subject child (SC) went to a concert in New York City with a 22-year-old male friend on 7/13/19. The mother met the 22-year-old previously and had no concerns for the teenager spending time with him. Just prior to leaving for the concert, the SC informed her mother that another male friend would be going with them. The mother reported she regularly went through the SC's phone and checked in with her constantly due to her historical behaviors. The mother reported she made several attempts to contact the SC on the night of the concert to no avail. The mother believed the SC and her friends had stopped at a rest area to rest as they had discussed doing that. The

mother said she was shocked when the police arrived in the morning and informed her the SC had been murdered by the 22-year-old.

OCDSS interviewed the 15-year-old surviving sibling and learned that she knew the 22-year-old man. She reported she felt comfortable around him and never worried about the SC with him. The sibling reported she frequently spent time with the SC and the 22-year-old. The sibling said the relationship with the SC had been strained in the past due to the SC's behaviors, but they recently began spending more time together and were repairing their relationship. The sibling said her mother worked hard to protect her and the SC. The sibling reported her mother put door alarms on the SC's door and regularly went through her phone.

OCDSS assessed the safety of the surviving sibling and the other children living in the home immediately upon learning about the death. The children were observed to be safe in the care of the three adults residing in the home. There were ongoing concerns for the surviving sibling as her behaviors were increasingly destructive. OCDSS provided intensive services for the family for additional support.

The autopsy report had not been received at the time of this writing. There was an ongoing criminal case against the 22-year-old man and he remained incarcerated at the time of this writing.

OCDSS conducted a thorough review of CPS history for the family and contacted the county personnel associated with the family during their long-term Preventive and Foster Care services. It was learned the SC had a history of risky and impulsive behaviors. The SC was placed in several residential facilities within the two years prior to her death as a result of her behaviors. During her placement, the SC ran away with older men she met on the internet and engaged in sexually exploitive behaviors. During that time, the mother engaged with services and acted appropriately in meeting the SC's needs for supervision.

OCDSS interviewed the father of the SC and sibling. The father resided out of state and reported no concerns for the care the mother provided to the children. The father did not have regular and consistent contact with either teenager.

At the time of this writing, the investigation remained open. The safety assessments were fitting to the case circumstances. OCDSS provided the family with a multitude of community based services as well as ongoing Preventive Services.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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
051124 - Deceased Child, Female, 17	051821 - Mother, Female, 35 Year(s)	DOA / Fatality	Pending

051124 - Deceased Child, Female, 17	051821 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Pending

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: The RAP had not yet been completed at the time of this writing, though a multitude of services were being provided to the family.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: Despite safety factors being present on the safety assessments, there was no need for a removal of the surviving sibling nor any other children residing in the home. The children were all deemed safe with their parents/caretakers and remained in the home.				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	The 22-year-old man alleged to be the boyfriend	Pending	pending
Comments:	The 22-year-old that stabbed the subject child was charged with murder in the 2nd degree and plead not guilty at the initial appearance. The charges were pending in criminal court.		

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:
A multitude of services were provided to the family prior to and following the death of the teenager. The family had intensive aftercare services in place for the teenager prior to her death and for the surviving sibling following the death. Community based bereavement services were offered and utilized by the family.

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:
A multitude of services were provided to the sibling immediately following the fatality. The sibling was receiving placement prevention services from an agency that was in contract with OCDSS. Additionally, OCDSS provided bereavement counseling. The sibling was already engaged in mental health services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS provided the mother with information on bereavement and mental health counseling as well as the additional support from Preventive Services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
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)
08/09/2018	Deceased Child, Female, 16 Years	Mother, Female, 34 Years	Emotional Neglect	Unsubstantiated	No
	Deceased Child, Female, 16 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 16 Years	Mother, Female, 34 Years	Sexual Abuse	Unsubstantiated	

Report Summary:
The report was received on 8/9/18, and alleged the mother was psychologically manipulating the teenager. The mother was telling relatives and friends that the teenager was psychotic, bipolar, and schizophrenic. The mother called the police on the teenager and she was sent to a psychiatric hospital. Also, the mother had a friend on social media that was a pedophile. The adult male was paying the teenager to send him nude pictures online. The mother was aware of the interaction, but failed to intervene.

Report Determination: Unfounded **Date of Determination:** 09/03/2018

Basis for Determination:
OCDSS determined there was no credible evidence to substantiate the allegations of IG, EN, and SA. The mother had been consistently following recommendations made by OCDSS and the probation department and was compliant with services. There was no evidence that she allowed the teenager to leave the home to be with her adult boyfriend. The mother appropriately contacted LE each time the teenager left the home. At the time the case was closed, the subject child was placed in a residential facility for a diagnostic evaluation due to her increasingly risky behaviors.

OCFS Review Results:
OCDSS assessed safety of the SS within 24 hours and found there to be no immediate safety concerns. OCDSS fully completed all casework activity in a timely fashion, commensurate with case circumstances. OCDSS appropriately determined the allegations given the information obtained during the investigation.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/21/2018	Deceased Child, Female, 16 Years	Mother, Female, 34 Years	Other	Unsubstantiated	Yes

Report Summary:
A Court Ordered Investigation was ordered by Oneida County Family Court with a return date of September 27, 2018.

Report Determination: Unfounded	**Date of Determination:** 10/02/2018

Basis for Determination:
OCDSS determined there was no credible evidence to substantiate the allegation of OTH/COI. The court ordered investigation was the result of a violation petition filed by the Oneida County Probation Department regarding the teenager. The violation was filed as the teenager cut off her ankle monitoring device and ran away from the home to be with her adult boyfriend. The mother had been consistently following recommendations made by OCDSS and the probation department and was compliant with services. There was no evidence that she allowed the teenager to leave the home to be with her adult boyfriend. The mother appropriately contacted LE each time the teenager left the home.

OCFS Review Results:
OCDSS mailed a notification letter to the father within the appropriate timeframe, but did not make attempts to contact or interview the teenager's father on the phone or in person despite a phone number being provided for him in the intake report.

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

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

Summary:
OCDSS did not interview the father of the subject child despite a phone number being provided for him.

Legal Reference:
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)
01/03/2018	Deceased Child, Female, 16 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The report was received on 1/3/18, alleging in August 2017, the subject child ran away from home with a 19-year-old man from Long Island. The mother was aware of the situation. The man came to the mother's home in October 2017 and the mother allowed the man into the home to see the teenager and allowed them to be alone together. While alone, the two had sexual intercourse. The man posted videos of the sexual encounter on social media accounts. The police were contacted. The teenager had several mental health diagnoses.

Report Determination: Unfounded	**Date of Determination:** 08/31/2018

Basis for Determination:
OCDSS determined there was no credible evidence to substantiate the allegations of IG against the mother. Through interviews with the mother, it was learned that she believed the teenager and the man were just friends. The mother had no knowledge the two were sexually active and upon finding out about the sexual activity, the mother appropriately refused to allow the teenager to see the man. OCDSS opened the case for mandated preventive services and a PINS petition was filed.

OCFS Review Results:
OCDSS assessed and documented safety and risk appropriately. OCDSS appropriately determined the allegations given

the information obtained during the investigation. OCDSS entered notes in the case record up to six months after the event date.
Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No
Issue: Timely/Adequate Case Recording/Progress Notes **Summary:** OCDSS entered several notes up to 6 months after the event date. **Legal Reference:** 18 NYCRR 428.5 **Action:** All progress notes will be entered as close to the event dates as possible.

[redacted]

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

9/5/12-11/14/12: Unfounded against the mother and father for inadequate guardianship regarding the subject child and her sibling.

Known CPS History Outside of NYS

There is no known history outside of New York State.

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: 02/08/2018

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 02/08/2018

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
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?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine

Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

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 FASP was 49 days overdue.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

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: OCDSS contracted out to Kids Oneida to provide after care services to the teenager following her discharge from St. Anne's Institute. While in FC, St. Anne's Institute provided services to the family.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☒Yes ☐No

Issue:	Failure to Monitor
Summary:	There is no documentation in the case record that a CPS worker monitor was assigned to the case.
Legal Reference:	18 NYCRR 432.2(b)(5)
Action:	When CPS is not the primary service provider for a CPS case, the LDSS is responsible for monitoring the provision of services including foster care services, to children and families named in open indicated abuse and maltreatment reports.

Preventive Services History

A Preventive Service case was opened on 2/8/18 and remained open at the time of the death. The case was open due to behavioral concerns the subject child was exhibiting. Additionally, the child was struggling with depression and social anxiety. She had incidents of over-dosing and running away from home with older men. During the Preventive Services case, the child was placed in a residential facility as the mother could no longer control her behaviors and she continued to violate the conditions of her probation. The child was in placement until 2/13/19. Upon discharge, Preventive Services remained in place in order to provide aftercare services and support for the family.

Foster Care Placement History

Foster Care services were in place for the subject child from 7/18/18 until her discharge home on 2/13/19. Initially, the subject child was placed for a 90-days psychological evaluation following an incident where she cut off her ankle monitor and ran away with an older male, violating her court orders. As a result of the diagnostic evaluation, it was recommended the child be placed for at least 6 months.

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