Office of Children and Family Services

# Child Fatality Report

## Report Identification Number: SY-20-041

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

## Issue Date: Feb 12, 2021

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 | ASTO-Allowing Sex Abuse to Occur | |

## Case Information

**Report Type:** Child Deceased
**Age:** 12 year(s)
**Jurisdiction:** Oneida
**Gender:** Female
**Date of Death:** 08/27/2020
**Initial Date OCFS Notified:** 08/27/2020

### Presenting Information

On 8/27/20, Oneida County Department of Social Services (OCDSS) received a report from the SCR which alleged that the 12-year-old child had been complaining of abdominal pain and was increasingly thirsty since 8/25/20. On 8/26/20, the mother and 18-year-old sibling found the child unresponsive in the home and placed her in the car to drive to the nearest hospital. Upon arrival at the hospital, the child was unresponsive, and CPR was performed for approximately 40 minutes. The child was stabilized and was transferred to another facility for further treatment. The child's condition continued to worsen, and the child passed away on 8/27/20 at 10:31 AM. The mother's failure to seek medical care in a timely manner resulted in the child's death. The roles of the surviving sibling and parent substitute were unclear.

### Executive Summary

This report concerns the death of a 12-year-old subject child which occurred on 8/27/20. The child was in the care of her mother on 8/25/20, when she began to display signs of a serious illness. The symptoms became increasingly worse throughout the day on 8/26/20 before the mother sought medical attention for the subject child. At the time of the child's death she lived with her mother, parent substitute, an adult sibling, and the parent substitute's 16-year-old child. The 16-year-old child was assessed to be safe in the care of his paternal grandfather. The 16-year-old child remained in the care of his grandfather throughout the investigation. At the time of the child's death, there was an open investigation regarding the mother's delay in obtaining treatment for the child.

OCDSS received the report from the SCR and coordinated their investigation with law enforcement and hospital staff. Through joint interviews with the mother and 18-year-old surviving sibling, it was learned that the child had complained of abdominal pain and thirst beginning during the evening of 8/25/20. The mother advised the child to rest, and believed the child had a minor illness or was beginning her menses. On 8/26/20 at approximately 9:00 AM, the surviving sibling found the child passed out on the floor of the bathroom and was minimally responsive when the sibling attempted to wake her. The mother and sibling carried the child to the couch and described the child's body to be limp. The mother attempted to have the child take sips of a sports drink in the early afternoon. Around 7:30PM, the mother and sibling found the child still on the couch and cold to the touch. The mother and sibling put the child in the bath to warm her up. She became completely unresponsive and was carried to the car by the parent substitute. The mother and surviving sibling drove the child 45 minutes to the nearest hospital.

Upon their arrival at the hospital, the medical staff began treatment of the child in the parking lot, stabilized her, and then transferred her to another facility for a higher level of care. The child subsequently was diagnosed with and passed away due to diabetic ketoacidosis and cardiac arrest. No autopsy was performed as the medical examiner felt the cause of death was obvious. Medical providers from the hospital expressed concerns that the family did not realize how gravely ill the child was and believed the child would be alive if the family sought medical attention upon finding the child minimally responsive on the bathroom floor on the morning of 8/26/20.

Through familial and collateral interviews, OCDSS found some credible evidence to substantiate the allegations of DOA/Fatality, Lack of Medical Care, and Inadequate Guardianship against the mother. OCDSS offered the family services in relation to the death of the child and closed their investigation.

## 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 spoke with all family members and appropriate collateral contacts prior to making a determination of the allegations and closing the investigation.

**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:**
OCDSS documented supervisory consultation throughout the investigation.

## Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment. |
| **Summary:** | The 30-Day Fatality report was completed on 10/6/20, six days late. |
| **Legal Reference:** | CPS Program Manual, Chapter 6, K-2 |
| **Action:** | OCDSS will complete the 30-Day Fatality Report in Connections within 30 days of receipt of the SCR reported child fatality. |

## Fatality-Related Information and Investigative Activities

# Child Fatality Report

## Incident Information

**Date of Death:** 08/27/2020 **Time of Death:** 10:31 AM

**Date of fatal incident, if different than date of death:** 08/26/2020
**Time of fatal incident, if different than time of death:** 07:30 PM

**County where fatality incident occurred:** Oneida
**Was 911 or local emergency number called?** No
**Did EMS respond to the scene?** No
**At time of incident leading to death, had child used 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
**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 | Adult Sibling | No Role | Female | 18 Year(s) |
| Deceased Child's Household | Deceased Child | Alleged Victim | Female | 12 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 44 Year(s) |
| Deceased Child's Household | Mother's Partner | No Role | Male | 40 Year(s) |
| Deceased Child's Household | Other Child - Mother's partner's son | No Role | Male | 16 Year(s) |
| Other Household 1 | Father | No Role | Male | 39 Year(s) |

## LDSS Response

OCDSS received the SCR report and coordinated their response with LE. The SM was interviewed at the hospital with LE. The SM stated that on the night of 8/25/20, the SC complained of abdominal pain. The SM believed the SC to have a minor stomach illness or potentially her menses and advised the SC to get rest. The SS informed the SM the following morning that she found the SC asleep on the floor of the bathroom. The SM informed OCDSS that she and the SS moved the SC from the bathroom floor to the living room couch. OCDSS documented in the record that it is unclear if the SM checked on the child again until after 7:00 PM. After 7:00 PM the SM and SS put the SC into the bath. The SM stated the SC felt cold. While in the bath, the SC became unresponsive. The SM stated this is when she decided to seek medical attention and had the PS and SS assist with putting the SC in the car to go to the hospital. The SM denied that the SC had not previously displayed signs of diabetes and there was no known family history of diabetes.

The SS was interviewed initially in the hospital. The SS confirmed that the SC had not been feeling well on the evening of 8/25/20. The SM advised the SC to rest and the SC went to sleep. The SS stated that she awoke around 9:00 AM on 8/26/20 and found the SC asleep on the floor of the bathroom. The SS stated that the SC was acting strange and described her as minimally responsive to verbal prompts. The SS stated that she told the SM about the SC's condition, and they carried the SC to the couch. The SS described the SC as "dead weight" while being carried to the couch. The SS went to work and returned home at approximately 7:00 PM. The SS stated she and the SM carried the SC to the bathroom to take a warm bath. The SS stated she went to change her clothes, then the SM stated that the SC needed to go to the hospital. The SS went with the SM and SC and did not call 911. The SS stated she rode in the backseat of the car with the SC and as they pulled into the hospital parking lot, she could hear the SC gurgling, and that she was completely unresponsive. The SS stated the SC had not shown signs of an illness like this in the past.

The PS was interviewed in the home and confirmed that the SC had not been feeling well on 8/25/20 and that on 8/26/20, he carried the SC to the car. The PS had a 16-year-old son (OC) who was identified in the report and was living with his grandfather. The OC was interviewed in his grandfather's home. The OC disclosed no concerns for the SC in the household and continued to live outside of the home throughout the investigation.

Upon arrival at the hospital, the SC was stabilized and transferred to another facility for a higher level of care. The child was diagnosed with Diabetic Ketoacidosis (DKA) and passed away due to DKA and cardiac arrest. Records showed the SC had a temperature of 91.6 degrees and a blood sugar level of 826 at arrival. The doctor who treated the SC disclosed that early signs of DKA can go overlooked and expressed concern that the family did not realize how gravely ill the SC was. The doctor stated the SC would have survived if she received medical attention earlier that day. No autopsy was performed.

OCDSS documented multiple attempts to reach the biological father of the SC. The attempts made were unsuccessful with making direct contact.

OCDSS obtained pediatric records for the SC. There were no indications in her medical history to indicate she was developing diabetes. It was disclosed that the SC had been to the dentist on 8/24/20 for a cleaning. OCDSS spoke with the dental provider was informed that the SC seemed disoriented during her appointment; however, the hygienist had no previous interactions with the SC to refer to.

After supervisory and legal consultation, OCDSS substantiated the allegations of Inadequate Guardianship, DOA/Fatality, and Lack of Medical Care against the SM and closed the investigation.

## 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:** Hospital physician

## 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
**Comments:** Oneida county has an OCFS approved Child Fatality Review Team.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 055762 - Deceased Child, Female, 12 Yrs | 055763 - Mother, Female, 44 Year(s) | DOA / Fatality | Substantiated |
| 055762 - Deceased Child, Female, 12 Yrs | 055763 - Mother, Female, 44 Year(s) | Inadequate Guardianship | Substantiated |
| 055762 - Deceased Child, Female, 12 Yrs | 055763 - Mother, Female, 44 Year(s) | Lack of Medical Care | 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?** | ☒ | ☐ | ☐ | ☐ |

**Additional information:**
OCDSS made diligent efforts to speak with the biological father of the SC. Their attempts were unsuccessful.

## 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:**
Risk was assessed throughout the investigation and OCDSS offered the family services in relation to the child's death. Services were declined by 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?** | ☐ | ☒ | ☐ | ☐ |

## Legal Activity Related to the Fatality

**Was there legal activity as a result of the fatality investigation?** There was no legal activity.

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

| Services | Provided After Death | Offered, but Refused | Offered, Unknown if Used | Not Offered | Needed but Unavailable | N/A | CDR Lead to Referral |
|---|---|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Bereavement counseling** | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Economic support** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Funeral arrangements** | ☐ | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ |
| **Housing assistance** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Mental health services** | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Foster care** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Health care** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Legal services** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Family planning** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Homemaking Services** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Parenting Skills** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Domestic Violence Services** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Early Intervention** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Alcohol/Substance abuse** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Child Care** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Intensive case management** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Family or others as safety resources** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Other** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?** No
**Explain:**
Service referrals were provided to the family. The 16-year-old OC was engaged in services separate from the services offered.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** No
**Explain:**
Information on available services was provided to the SM. The record reflects the family did not engage in the services offered.

## 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?** 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) |
|---|---|---|---|---|---|
| 08/27/2020 | Deceased Child, Female, 12 Years | Mother, Female, 44 Years | Inadequate Guardianship | Substantiated | No |
| | Deceased Child, Female, 12 Years | Mother, Female, 44 Years | Lack of Medical Care | Substantiated | |

**Report Summary:**
The SCR report alleged that for a couple of days the SC was complaining of abdominal pain, increased thirst, and at one point was lethargic and lying on the bathroom floor. The SM knew about the SC's condition and failed to seek medical attention.

**Report Determination:** Indicated | **Date of Determination:** 12/10/2020

**Basis for Determination:**
OCDSS conducted interviews with the alleged subject and collateral contacts. Medical professionals stated the child would not have died had the mother not delayed in seeking medical intervention for the child.

**OCFS Review Results:**
OCDSS completed all regulatory requirements for their investigation. Relevant collateral contacts were made to support the investigation determination. Safety and risk were assessed throughout the investigation. OCDSS provided the family with information for services following the death of the SC.

**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) |
|---|---|---|---|---|---|
| 02/13/2020 | Sibling, Female, 17 Years | Mother, Female, 43 Years | Inadequate Guardianship | Unsubstantiated | No |
| | Other Child - Mother's Partner's Child, Male, 16 Years | Mother, Female, 43 Years | Inadequate Guardianship | Unsubstantiated | |
| | Sibling, Female, 17 Years | Mother, Female, 43 Years | Childs Drug / Alcohol Use | Unsubstantiated | |
| | Sibling, Female, 17 Years | Mother's Partner, Male, 40 Years | Childs Drug / Alcohol Use | Unsubstantiated | |
| | Sibling, Female, 17 Years | Mother's Partner, Male, 40 Years | Inadequate Guardianship | Unsubstantiated | |
| | Other Child - Mother's Partner's Child, Male, 16 Years | Mother's Partner, Male, 40 Years | Inadequate Guardianship | Unsubstantiated | |
| | Other Child - Mother's Partner's Child, Male, 16 Years | Mother's Partner, Male, 40 Years | Parents Drug / Alcohol Misuse | Unsubstantiated | |

**Report Summary:**
The SCR report alleged that the 16-year-old OC was locked out of the home and the SM and PS would not let him back in the home. The report also alleged that the PS smoked marijuana in the home and provided it to the 17-year-old SS.

**Report Determination:** Unfounded | **Date of Determination:** 04/23/2020

**Basis for Determination:**
OCDSS interviewed the family and only the 16-year-old OC disclosed any of the allegations to have validity. All other

family members denied the allegations and OCDSS found no credible evidence to substantiate the allegations through familial and collateral contacts.

**OCFS Review Results:**
OCDSS interviewed relevant family members and collateral contacts during their investigation. The OC claimed the allegations in the report were true and no other family member corroborated the information. There was no credible evidence found to support the allegations. OCDSS completed all regulatory requirements during their 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) |
|---|---|---|---|---|---|
| 10/09/2018 | Sibling, Female, 16 Years | Mother, Female, 42 Years | Inadequate Guardianship | Unsubstantiated | No |
| | Sibling, Female, 16 Years | Mother, Female, 42 Years | Lacerations / Bruises / Welts | Unsubstantiated | |
| | Sibling, Female, 16 Years | Mother, Female, 42 Years | Other | Unsubstantiated | |
| | Sibling, Female, 16 Years | Mother's Partner, Male, 38 Years | Inadequate Guardianship | Unsubstantiated | |
| | Sibling, Female, 16 Years | Mother's Partner, Male, 38 Years | Other | Unsubstantiated | |
| | Sibling, Female, 16 Years | Other Adult - Biological Father to SS, Male, 51 Years | Inadequate Guardianship | Unsubstantiated | |
| | Sibling, Female, 16 Years | Other Adult - Biological Father to SS, Male, 51 Years | Other | Unsubstantiated | |

**Report Summary:**
The SCR report alleged that the PS kicked in the OC's door, the SM kicked the SS down the stairs, and the SM and PS were verbally abusive.

**Report Determination:** Unfounded | **Date of Determination:** 01/18/2019

**Basis for Determination:**
The SS stated that the incidents occurred, and that she was kicked out of the home by the SM. The SM, PS, and OC denied the allegations and the SM provided text messages to OCDSS from the SS identifying she ran away to live with a relative and the BF had filed for custody of her.

**OCFS Review Results:**
OCDSS interviewed all family members regarding the allegations in the report. The SM, PS, and OC all denied the allegations in the report. The SS stated the allegations were true, however, the SM provided OCDSS with text messages from the SS to corroborate their version of events. OCDSS closed their investigation after completing all regulatory requirements.

**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) |
|---|---|---|---|---|---|
| 05/24/2018 | Sibling, Female, 16 Years | Mother, Female, 42 Years | Inadequate Guardianship | Unsubstantiated | No |

| | | | | |
|---|---|---|---|---|
| | Sibling, Female, 16 Years | Mother, Female, 42 Years | Lacerations / Bruises / Welts | Unsubstantiated |

**Report Summary:**
The SCR report alleged that the SM hit the SS with a belt and fists, and made verbal threats towards the SS.

**Report Determination:** Unfounded | **Date of Determination:** 09/20/2018

**Basis for Determination:**
OCDSS interviewed all family members and relevant collateral contacts. The SS was observed to have no marks or bruises and recanted the allegations. The SM disclosed that the SS had a history of running away and OCDSS referred the family to mental health services.

**OCFS Review Results:**
OCDSS interviewed all family members and relevant collateral contacts. OCDSS referred the family for services to address the ongoing issues between the SM and the SS. Safety and risk of the children was assessed throughout the investigation and OCDSS made the decision to close their investigation after completing all regulatory requirements.

**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) |
|---|---|---|---|---|---|
| 03/06/2018 | Other Child - Mother's Partner's Child, Male, 14 Years | Mother's Partner, Male, 38 Years | Inadequate Guardianship | Unsubstantiated | No |
| | Other Child - Mother's Partner's Child, Male, 14 Years | Mother's Partner, Male, 38 Years | Swelling / Dislocations / Sprains | Unsubstantiated | |
| | Sibling, Female, 15 Years | Mother's Partner, Male, 38 Years | Inadequate Guardianship | Unsubstantiated | |
| | Sibling, Female, 15 Years | Adult Sibling, Male, 20 Years | Childs Drug / Alcohol Use | Unsubstantiated | |
| | Other Child - Mother's Partner's Child, Male, 14 Years | Adult Sibling, Male, 20 Years | Inadequate Guardianship | Unsubstantiated | |

**Report Summary:**
The SCR report alleged that the PS pushed the OC and he banged his head and sustained a bump. A subsequent report was received alleging the adult sibling was abusing drugs in the presence of the OC and used drugs with the SS.

**Report Determination:** Unfounded | **Date of Determination:** 06/12/2018

**Basis for Determination:**
The allegations of the physical incident between the PS and OC were denied by all parties. The family all identified knowledge of drug use by the adult sibling and he was arrested and incarcerated prior to the investigation. All denied that the adult sibling used drugs with any of the children in the home or in their presence.

**OCFS Review Results:**
OCDSS interviewed family members regarding the incidents reported. The PS and OC denied any allegations of a physical incident and the family disclosed knowledge of the adult sibling's drug use prior to his arrest. OCDSS obtained collateral information to support the determination of the allegations in the report and closed the investigation.

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

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

The SM was named as a subject on 7 historical reports that were more than three years prior to the fatality report. There were two substantiated reports against the mother for educational neglect of the SS. The SM was also named on one

substantiated report due to domestic violence with the BF in the presence of the children. Additionally, there were historical court ordered services in 2014 which were put in place due to the SM and BF exposing the SC and SS to dangerous conditions in the home, manufacturing illicit substances in the home, and using illicit substances.

## Known CPS History Outside of NYS

There was no known history outside of NYS.

## 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