Office of Children and Family Services

# Child Fatality Report

## Report Identification Number: SY-20-059

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

## Issue Date: Jun 14, 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:** 2 year(s)
**Jurisdiction:** Broome
**Gender:** Female
**Date of Death:** 12/18/2020
**Initial Date OCFS Notified:** 12/18/2020

### Presenting Information

An SCR report alleged the 2-year-old child was ill with a respiratory condition. The child's condition worsened when the child was in the babysitter's care. The babysitter notified the mother that the child struggled to breathe and needed medical attention. Despite the severity of the child's condition, the adults delayed medical care. On 12/18/2020, at 5:45 AM, the babysitter left her 17-year-old daughter to care for the child. She checked on the child and found her unresponsive. EMS transported the child to the hospital where she was pronounced dead at 11:06 AM. A subsequent report noted the child's feet were swollen. The child's hair was infested with headlice and her basic hygiene was neglected. Additionally, the conditions of the babysitter's home were unsanitary, unsafe and hazardous. The adults were aware of the home's condition and did not ensure the children had a safe, sanitary environment.

### Executive Summary

This fatality report concerns the death of the 2-year-old female subject child that occurred on 12/18/2020. Two reports were made to the SCR on the same day alleging the child died while in the care of the babysitter's 17-year-old daughter. The child's parents and babysitter were aware the child was ill prior to her death yet did not seek medical attention for the child. Additionally, the child and the babysitter's children, ages 9 and 17 years, were infested with headlice and their home was uninhabitable. The 9-year-old was also the father's child. At the time of the child's death, she resided with her father and grandmother; however, was regularly in the care of the babysitter at the babysitter's home. The mother had a 1-year-old child who resided with his father. The mother did not see the child or the sibling on a regular basis nor was she a primary caretaker of her children. During the investigation, Broome County Department of Social Services (BCDSS) developed safety plans regarding the surviving children, and they were assessed throughout the investigation.

BCDSS coordinated investigative efforts with law enforcement upon receipt of the SCR reports. At the time this report was written, the outcome of the criminal investigation remained unknown; however, the district attorney's office planned to press charges against the adults, but the record did not specify details. An autopsy was performed, and the preliminary cause of death was listed as severe anemia leading to cardiac arrest. The final autopsy report was pending at the time this report was written.

BCDSS conducted home visits throughout the investigation and the home was not suitable for the babysitter's children. The children resided with the father until the home met minimal standards. The parents, babysitter and the 17-year-old child were interviewed. Although they were aware the child was ill and was struggling to breathe, they did not seek medical attention for the child. On the morning of 12/18/2020, the 17-year-old child found the subject child unresponsive and EMS was called. The child was transported to the hospital where life-saving measures were unsuccessful as it appeared the child had been deceased for approximately 5 hours before arriving at the hospital.

BCDSS spoke with collateral contacts including hospital staff, the pediatrician and service providers and schools of the babysitter's children. BCDSS adequately addressed concerns revealed during the investigation.

The Safety Assessments and required reports were completed timely and accurately. The investigation remained open at the time this report was written.

**PIP Requirement**

Regarding historical cases, BCDSS and Chemung County will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the counties have taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, the counties will review the plan and revise as needed to address ongoing concerns.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** N/A
- **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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

**Explain:**
The case remained open at the time this report was written; therefore, the investigation was not determined and the Safety Assessment due at the time of determination was not yet completed.

**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:**
The record reflected supervisory consultation. The investigation remained open at the time this report was written.

### Required Actions Related to the Fatality

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

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 12/18/2020 **Time of Death:** 11:06 AM

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

**County where fatality incident occurred:** Broome
**Was 911 or local emergency number called?** Yes
**Time of Call:** 09:57 AM
**Did EMS respond to the scene?** Yes
**At time of incident leading to death, had child used alcohol or drugs?** N/A
**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?** 2 Hours
**At time of incident was supervisor impaired?** Not impaired.
**At time of incident supervisor was:**

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **Unknown**

**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 | 2 Year(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 30 Year(s) |
| Deceased Child's Household | Grandparent | No Role | Female | 56 Year(s) |
| Other Household 1 | Mother | Alleged Perpetrator | Female | 26 Year(s) |
| Other Household 2 | Other - Babysitter | Alleged Perpetrator | Female | 46 Year(s) |
| Other Household 2 | Other Child - Babysitter's child | Alleged Victim | Female | 17 Year(s) |
| Other Household 2 | Sibling | Alleged Victim | Female | 9 Year(s) |

**LDSS Response**

On 12/18/2020, BCDSS received the fatality report from the SCR. A subsequent report was received and was consolidated. Within the first 24 hours of the investigation, BCDSS contacted the sources of the reports, gathered information from the hospital, coordinated investigative efforts with law enforcement and documented a CPS history check. Additionally, home visits were made, and the family was interviewed.

Law enforcement shared information they gathered. The child was estimated to have been deceased for approximately 5 hours before she was transported to the hospital. On the night prior to her death, between 8:00-9:00 PM, the child was asleep on the couch. Around 5:40 AM on 12/18/2020, the babysitter left the home, leaving the 17-year-old child responsible for the child. The 17-year-old child attempted to feed the child crackers around 8:00 AM; however, the child

did not want them and law enforcement believed the 17-year-old child attempted to force feed the child as the child was estimated to have been deceased at that time. At 9:30 AM, the 17-year-old child called the father, told him the child was unresponsive and 911 was called.

The hospital doctor said the child was in rigor mortis when she arrived at the hospital. There were no obvious signs of abuse upon external examination of the body. The mother told the doctor the babysitter said the child had trouble breathing and was coughing on 12/17/2020 and the parents planned to bring the child to the pediatrician the following day. A hospital social worker stated the child was sick for about a week before staying with the babysitter approximately 2 days prior to the child's death. The babysitter informed the parents the child was sick, and the babysitter did not think she could seek medical attention for the child as she was not her parent. The babysitter told the parents to bring the child to the doctor multiple times. When the babysitter was interviewed by BCDSS, her recollection of the days leading up to the fatality remained consistent with what was reported to law enforcement.

On 12/18/2020, a home visit was made to the father's home where he resided with the paternal grandmother. The grandmother knew the child was ill with cold symptoms and said the child did not have a fever. A safety plan was created that the 17-year-old child could not be unsupervised around the 9-year-old sibling and the children stayed with the father until the babysitter was able to clean her home. The 9-year-old sibling declined to be interviewed throughout the investigation. The 17-year-old child said she knew something was "very wrong" with the child on the morning of 12/18/2020 and contacted the father to inform him. The 17-year-old child expressed she cared for the child regularly.

During the interviews with the parents, they said they were aware the child was ill and the mother knew the child was struggling to breathe. On the morning of the death, the parents received a call from the 17-year-old child informing them of the child's condition and they went to the home. The father called 911 while the mother attempted CPR until first responders arrived. With exception to the days prior to the child's death, the mother had not seen the child in approximately a year. The father last saw the child on 12/15/2020 when he brought the child to the babysitter's house. He said he did not notice the condition of the babysitter's home and was aware the child had headlice since September 2020. The parents had no additional information.

The investigation remained open at the time this report was written.

## Official Manner and Cause of Death

**Official Manner:** Pending
**Primary Cause of Death:** Pending
**Person Declaring Official Manner and Cause of Death:** Unknown

## 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:** The death was referred to an OCFS approved Child Fatality Review Team.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 056342 - Deceased Child, Female, 2 Yrs | 056345 - Other - Babysitter, Female, 46 Year(s) | DOA / Fatality | Pending |

| | | | |
|---|---|---|---|
| 056342 - Deceased Child, Female, 2 Yrs | 056343 - Father, Male, 30 Year(s) | DOA / Fatality | Pending |
| 056342 - Deceased Child, Female, 2 Yrs | 056344 - Mother, Female, 26 Year(s) | DOA / Fatality | Pending |
| 056342 - Deceased Child, Female, 2 Yrs | 056345 - Other - Babysitter, Female, 46 Year(s) | Inadequate Guardianship | Pending |
| 056342 - Deceased Child, Female, 2 Yrs | 056343 - Father, Male, 30 Year(s) | Inadequate Guardianship | Pending |
| 056342 - Deceased Child, Female, 2 Yrs | 056344 - Mother, Female, 26 Year(s) | Inadequate Guardianship | Pending |
| 056342 - Deceased Child, Female, 2 Yrs | 056345 - Other - Babysitter, Female, 46 Year(s) | Lack of Medical Care | Pending |
| 056342 - Deceased Child, Female, 2 Yrs | 056343 - Father, Male, 30 Year(s) | Lack of Medical Care | Pending |
| 056342 - Deceased Child, Female, 2 Yrs | 056344 - Mother, Female, 26 Year(s) | Lack of Medical Care | Pending |
| 056346 - Sibling, Female, 9 Year(s) | 056345 - Other - Babysitter, Female, 46 Year(s) | Inadequate Guardianship | Pending |
| 056347 - Other Child - Babysitter's child, Female, 17 Year(s) | 056345 - Other - Babysitter, Female, 46 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?** | ☒ | ☐ | ☐ | ☐ |

**Additional information:**

The 9-year-old sibling declined to be interviewed on several occasions.

## 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** | ☒ | ☐ | ☐ | ☐ |

**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:**<br>No children were removed as a result of the fatality investigation. | | | | |

## Legal Activity Related to the Fatality

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

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

| Services | Provided After Death | Offered, but Refused | Offered, Unknown if Used | Not Offered | Needed but Unavailable | N/A | CDR Lead to Referral |
|---|---|---|---|---|---|---|---|
| **Bereavement counseling** | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Economic support** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Funeral arrangements** | ☐ | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ |
| **Housing assistance** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Mental health services** | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Foster care** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Health care** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Legal services** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Family planning** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Homemaking Services** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Parenting Skills** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Domestic Violence Services** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Early Intervention** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Alcohol/Substance abuse** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Child Care** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Intensive case management** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Family or others as safety resources** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Other** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?** Yes
**Explain:**
The children were referred for mental health services as a result of the fatality.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
The adults were provided with bereavement and mental health referrals.

## 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?** Yes

## 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) |
|---|---|---|---|---|---|
| 12/08/2020 | Sibling, Male, 11 Months | Other Adult - Father to sibling, Male, 30 Years | Inadequate Guardianship | Unsubstantiated | Yes |
| | Sibling, Male, 11 Months | Mother, Female, 26 Years | Inadequate Guardianship | Unsubstantiated | |

**Report Summary:**
Chemung County Department of Social Services (CCDSS) received an SCR report that alleged on 12/8/2020, the mother and the father of the 11-month-old sibling engaged in a verbal altercation in the presence of that sibling. The situation escalated to the mother and father of the sibling struggling over the sibling by grabbing at him. The sibling's maternal grandmother intervened and took the sibling from his father as the mother continued to grab the sibling. While the grandmother was holding the sibling, the sibling's father struck the mother in the face with his elbow, grabbed her by the neck and threw her to the ground. The grandparents had unknown roles.

**Report Determination:** Unfounded | **Date of Determination:** 02/22/2021

**Basis for Determination:**
The allegation of Inadequate Guardianship was unsubstantiated against the mother regarding the 11-month-old sibling. The investigation revealed the physical altercation occurred and the sibling's grandmother took the child to remove him from the situation and he did not appear fearful around his parents.

**OCFS Review Results:**
The investigation was initiated timely and the source of the report was contacted. A history check was completed timely. Notice of existence letters were provided timely and the 7-day Safety Assessment was completed timely and accurately. Home visits were made, and the subjects and children were interviewed. The record did not reflect attempts to contact all biological parents.

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

**Issue:**
Contact/Information From Reporting/Collateral Source

**Summary:**
The record did not reflect attempts to interview the mother of the 5-year-old other child or the mother to one of the 10-year-old unrelated children who lived in the house where the incident occurred.

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

**Action:**
CCDSS will contact or make diligent efforts to contact relevant collateral sources who may have information relevant to the investigation, including absent parents.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 03/20/2019 | Deceased Child, Female, 1 Years | Mother, Female, 24 Years | Inadequate Guardianship | Substantiated | Yes |

**Report Summary:**
An SCR report received by Broome County alleged on 3/20/19, the mother became angry because she was not allowed to have a vicious dog in the home. During the dispute, the mother became aggressive and broke a window while holding the 1-year-old subject child. The child remained physically unharmed. Law enforcement arrived and diffused the incident. The mother resisted arrest and was physically combative with law enforcement in the presence of the child. The role of the father was unknown.

**Report Determination:** Indicated | **Date of Determination:** 07/16/2019

**Basis for Determination:**
The allegation of Inadequate Guardianship was substantiated against the mother regarding the child. The mother was arrested for disorderly conduct, resisting arrest and endangering the welfare of a child. Thereafter, the child began residing solely with her father and grandmother.

**OCFS Review Results:**
The investigation was initiated timely and the source of the report was contacted. Relevant collaterals were contacted. Home visits were made, and the safety of the child was adequately assessed. Written notice of the SCR report was provided timely. The 7-day Safety Assessment and CPS history check were completed late.

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

**Issue:**
Timely/Adequate Seven Day Assessment
**Summary:**
Although the 7-day Safety Assessment was accurate, it was completed untimely on 3/29/19.
**Legal Reference:**
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
**Action:**
BCDSS will complete all safety assessments in the accordance with regulations.

**Issue:**
Review of CPS History
**Summary:**
Although documented, a history check was not completed until 4/14/19.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(i)
**Action:**
Within 1 business day of a report, BCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, BCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 01/24/2019 | Other Child - Babysitter's child, Female, 16 Years | Other Adult - Babysitter, Female, 45 Years | Lack of Medical Care | Unsubstantiated | No |

**Report Summary:**
An SCR report received by Broome County alleged the 17-year-old other child was prescribed medication and was engaged in counseling; however, they were discontinued in April 2018 as the babysitter failed to ensure her daughter attended her appointments. Eventually, the mental health services were reinstated, and the daughter was prescribed medication. In December 2018, the daughter's medication was not picked up, resulting in the daughter going without it. The role of the babysitter's 9-year-old sibling was unknown.

**Report Determination:** Unfounded | **Date of Determination:** 04/30/2019

**Basis for Determination:**
The allegations were unsubstantiated. The investigation revealed there was a lapse in the babysitter's daughter's mental health services as she refused to attend. The babysitter was appropriate in keeping contact with the providers and the babysitter's daughter's care was resumed. The medication was not picked up as there was a backorder with the pharmacy's warehouse. There was no credible evidence to substantiate the allegations.

**OCFS Review Results:**
The investigation was initiated timely, the source of the report and collateral contacts were made. Home visits were conducted, and the family was interviewed. The Safety Assessments were completed timely and accurately. A history check was documented. Written notice of the SCR report was provided timely.

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

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

12/10/13- 5/30/14 The PGM, SF and babysitter were unsubstantiated for the IG of the babysitter's children, and the LS of the 17-year-old child.

6/13/14- 7/24/14 The PGM, SF and babysitter were substantiated for the IG, IF/C/S of the babysitter's children.

6/24/15- 8/6/15 The babysitter was unsubstantiated for the IG and LS of her children.

12/5/16- 2/14/17 The babysitter was substantiated for the IG, EdN and IF/C/S for her children.

## Known CPS History Outside of NYS

There is no known CPS history outside of New York.

## Preventive Services History

On 2/2/17, a CPS worker referred the babysitter's family for preventive services as there were ongoing concerns the babysitter was unable to keep a clean home or consistently ensure her children were in school. The babysitter completed parent education services and the family received mental health counseling and assistance with connecting to medical providers during the open case. The case was closed on 6/8/2020 as the home had been kept at or above minimal standards. The case closed at the end of the school year and the service plan completed at the time of closing noted that BCDSS could not monitor the children's attendance at school because they were engaged in remote learning. There was a CPS Worker Monitor assigned to the case throughout the time Preventive Services were provided.

## 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

## Additional Local District Comments

BCDSS agrees with OCFS' fatality findings. BCDSS' 12/18/20 fatality investigation was conducted in conjunction with law enforcement. All subjects and collateral contacts were interviewed. All determinations and Safety Assessments were made timely. Additionally, appropriate/needed services were offered in this case.

Regarding OCFS regulatory findings concerning the 3/20/19 investigation, BCDSS completed the 7-day Safety Assessment on the 9th day, and the prior history requirement was completed and documented on 4/14/19.

Despite staff turnover and constraints imposed by COVID, through regulatory scheduled supervisory and Division meetings, BDCSS works with CPS staff on an ongoing basis concerning timely OCFS regulatory compliance.

## 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