NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: BU-16-009 **Prepared by: Buffalo Regional Office**

Issue Date: 8/30/2016

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

Case Information

Report Type: Child Deceased
Age: 13 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 12/13/2015
Initial Date OCFS Notified: 04/20/2016

Presenting Information

Subject Child (SC) (13) passed away 12/13/15. SC had a history of depression and mental health issues. SC was having suicidal ideations and subject mother (SM) knew this. SM had illegally obtained Desipramine (an antidepressant) and had left the pills accessible to the child. SM last saw the SC alive on 12/12/15 before bed. The morning of 12/13/15 SM checked and saw SC in her room, but didn't check her condition. SM then left the home leaving the SC home alone unsupervised. It was either during the night while unsupervised or after SM left, that the SC took the Desipramine pills and overdosed on them passing away. SC's cause of death is Acute Desipramine Intoxication. SM leaving the pills accessible and not adequately supervising SC knowing that she was having suicidal ideations resulted in SC's death. Other child (8) has an unknown role. Father has an unknown role.

Executive Summary

This fatality review involved the death of a thirteen year old female subject child in an open SCR report that passed away unexpectedly during the course of the open investigation. This fatality had previously been investigated, and this 6/19/16 fatality report was initiated during BRO OCFS review upon receipt of the final autopsy report which found a high level of Desipramine, an anti-depressant medication, that the Medical Examiner listed as the cause of death. SC was not prescribed any medications in the past or during the time of death.

The open SCR report, at the time of the fatality, did not involve the fatality incident and involved allegations of IFCS, IG, LSUP, and Parent D/A Misuse against SM. A subsequent report with allegations of IG and LBW against subject father (SF) was consolidated. There was no SCR fatality report made at the time of the fatality.

The open investigation included appropriate contacts including school personnel, family members, Pediatrician, law enforcement, first responders, and the Medical Examiner. Medical records, criminal background, SCR history checks, and documentation of case work activities were completed. There were no concerns reported by Pediatric or school personnel. The case record documented significant lapses in case activity including a 135 day lapse in case contact. This lapse is particularly significant because case work contact was renewed after learning SC had died. Required actions were made regarding these lapses in the initial fatality review. The need to maintain on-going contacts to provide on-going safety and risk assessment is especially poignant in this instance as there is a possibility that an opportunity to avoid SC’s circumstances of death may have been missed in this case.

This second investigation involving the fatality found no new information that was contrary to the initial investigation. No suicide note was found and no prior threat of suicide was made by SC. SC did have a history of cutting, depression, and being bullied on FB by her school peers. SC's Aunt reported SC had talked about suicide with friends and had recently given away many of her personal items. This was discovered after her death. There were no signs of trauma or other suspicious indicators reported observed in the home by first responders or law enforcement personnel. No criminal charges were made.

The Medical Examiner performed an autopsy and her final report listed the cause of death as “Acute Desipramine intoxication.” SC’s source of this anti-depressant medication is unknown. SM reported SC had no prescribed

medications. It was confirmed that SM, nor any other household member, had been prescribed this medication. The ME's opinion statement reported no trauma or anatomic cause of death and a 2.9mg level of Desipramine in SC's blood. A lethal dose is listed at 1-2mg. The ME estimated that SC would have had to ingest between 20-800 pills for this level of the drug to be in SC's body at the time of death. The ME listed the manner of death as "undetermined" due to uncertainty regarding the intentionality of the overdose.

On 06/17/2016, the second fatality investigation was closed UNFOUNDED. The source of where SC obtained the medication Desipramine continues to be unknown and there is no credible evidence to support SM having this medication in the home. While SC had some history of depression, no one reported SC having made any threats of self-harm or appearing overtly depressed prior to her death. At the time of the fatality, grief counseling was accepted by SM and preventive services were declined. Following this investigation, preventive services were re-offered by the Caseworker and SM accepted these services along with counseling for the younger surviving sibling. The surviving children were determined to be safe at case closing. Preventive services involvement will provide further oversight.

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:
Case activity was commensurate with the case circumstances of this fatality 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:
The decision to close this fatality investigation by the local district was appropriate. A preventive services case was opened on 06/14/2016 and the surviving children appeared safe at the time of case closing. The preventive services case involvement will provide continued oversight.

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: 12/13/2015 **Time of Death:** Unknown

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

County where fatality incident occurred: ERIE
Was 911 or local emergency number called? Yes
Time of Call: 10:38 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 3 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	13 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	42 Year(s)
Deceased Child's Household	Sibling	No Role	Male	18 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Other Household 1	Father	No Role	Male	43 Year(s)

LDSS Response

On 7/29/15, Erie Co. CPS received an SCR report with allegations of IFCS, IG, LSUP, and Parent D/A Misuse against subject mother (SM). A subsequent 9/8/15 report with allegations of IG and LBW against SF was consolidated. During the course of this investigation, SC unexpectedly passed away on 12/13/15. At that time, there was no SCR fatality report made regarding this fatality. On 04/19/2016, during the initial OCFS review, an SCR fatality report was made following information in the final autopsy report listing a medicine over dose as the cause of SC's death. This information had not been available prior to the initial investigation closing,

The CW made case and collateral contacts including school personnel, family members, Pediatrician, law enforcement, first responders, and the Medical Examiner. Medical records, criminal background, SCR history checks, and documentation of case work activities were completed. There were no concerns reported by Pediatric or school personnel. Pertaining to the open investigation, the allegations of IFCS, IG, and Parent D/A Misuse against SM were UNF. The allegations of IG and LBW against SF were IND. Criminal charges and an OOP prohibiting SF's contact with SC were made against SF by law enforcement. Following SC's death, the charges and OOP were dropped.

Pertaining to the 4/19/16 fatality report, the Caseworker found no new information that was contrary to the initial investigation. A home visit and assessment was made within 24-hours with no safety concerns found regarding the surviving children. The SM reported leaving the home in the morning, on the day of the fatality, to bring coffee to her father and returned a few hours later finding SC on the floor cold to the touch and with blue lips. She called 911 and EMS responded. SM and a neighbor attempted CPR until EMS arrived. First responders reported SC was non-responsive to resuscitation efforts and was DOA at the scene. SM and family members reported no suicide note was found and no prior threat of suicide was made by SC. SC did have a history of cutting, depression, and being bullied by her school peers. SC's Aunt reported SC had talked about suicide with friends and had recently given away many of her personal items. This was discovered after her death. There were no signs of trauma or other suspicious indicators reported as observed in the home by first responders or law enforcement personnel. No criminal charges were made regarding the fatality.

The Medical Examiner performed an autopsy and her 3/3/16 final report listed the cause of death as "Acute Desipramine intoxication". This is an anti-depressant and SC's source of this medication remains unknown. SM reported SC was not prescribed any medications and no one in the home was prescribed this medication. Information from school personnel regarding teen "bowl parties" in the area where teens steal medications and mix them in a bowl and then pass the bowl during the party was explored. This source; however, is unlikely due to SC having only the one drug in her system. The Medical Examiner's opinion statement reported no trauma or anatomic cause of death and a 2.9mg level of Desipramine in SC's blood. A lethal dose is listed at 1-2mg. The manner of death is undetermined due to uncertainty regarding the intentionality of the overdose.

On 6/17/16, the allegations of DOA/Fatality, IG, and Lack of Sup against SM were UNF. There is no credible evidence to support SM being aware SC was having suicidal ideation or SM having this medication in the home. At the time of the fatality, SM had begun counseling, but declined offered services. At the closing of this investigation, the Caseworker re-offered preventive services and SM accepted these services along with adding counseling for the younger surviving sibling. The surviving children were determined to be safe at case closing. Preventive services involvement will provide further oversight.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Comments: The investigation complied with approved protocols and coordinated with the law enforcement investigation.

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

Comments: There was no review by an OCFS approved Fatality Review Team as Erie County does not have an approved Fatality review team, but the fatality investigation was reviewed by a Multi-disciplinary team and appropriate protocols were followed in coordinating the investigation with law enforcement personnel.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
030221 - Deceased Child, Female, 13 Yrs	030223 - Mother, Female, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
030221 - Deceased Child, Female, 13 Yrs	030223 - Mother, Female, 42 Year(s)	DOA / Fatality	Unsubstantiated
030221 - Deceased Child, Female, 13 Yrs	030223 - Mother, Female, 42 Year(s)	Lack of Supervision	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint	☒	☐	☐	☐

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

Additional information:
This report was a fatality report of a previously investigated fatality incident. The report was made due to new findings from the final autopsy report which determined the cause of subject child's death as "Acute Desipramine intoxication."

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 safety 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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Explain as necessary:
No children were removed 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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

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

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

Other, specify: A Preventive Services case was opened 6/14/2016.

Additional information, if necessary:
Grief counseling was accepted for SM and preventive services were declined at the time of the fatality during the initial investigation. Preventive services were re-offered by the CW during this second fatality investigation and were accepted by the subject mother along with counseling for the youngest surviving sibling. A preventive services case was opened on 06/14/2016

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:
Grief counseling and preventive services were offered for the surviving children by the Caseworker. While these services were declined at the time of the fatality incident, they were re-offered and accepted prior to close of this second fatality investigation and a preventive services case was opened on 06/14/2016.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Following the fatality incident, subject mother made suicidal comments and did accept offered grief counseling for herself and began participation with a mental health provider. Preventive services were offered by the Caseworker at that time, and were declined, however; they were re-offered again and accepted during this second fatality investigation. A preventive services case was opened on 06/14/2016.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/08/2015	10245 - Deceased Child, Female, 13 Years	10248 - Father, Male, 42 Years	Lacerations / Bruises / Welts	Indicated	No
	10245 - Deceased Child, Female, 13 Years	10248 - Father, Male, 42 Years	Inadequate Guardianship	Indicated	

Report Summary:
On 8/31/15 at 8PM, bio-father grabbed subject child (13) by the face and arm. He then twisted her arm behind her back and pushed her up against a wall before throwing her on the ground. SC sustained multiple bruises in this incident. Roles for SM and sibling (18) are unknown.

Determination: Indicated | **Date of Determination:** 02/17/2016

Basis for Determination:
Allegations of IG and L/B/W against father with respect to SC are INDICATED. It is determined that there is some credible evidence to substantiate the allegations. SC informed CW that her father attacked her while she was at a store. Sibling (18) was present for this and he advised that he and SC were going to the store and their father saw them. Father tried to talk with SC and SC refused to speak with him. Sibling (18) informed that his father did grab SC and assaulted her outside of the store. SC was upset by this as she was seen crying per her sibling. Charges were pressed against father and an OOP issued against father. Father was reportedly intoxicated during incident.

OCFS Review Results:
No concerns upon BRO OCFS review.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/29/2015	10241 - Deceased Child, Female, 13 Years	10242 - Mother, Female, 42 Years	Inadequate Food / Clothing / Shelter	Unfounded	No
	10241 - Deceased Child, Female, 13 Years	10242 - Mother, Female, 42 Years	Parents Drug / Alcohol Misuse	Unfounded	
	10244 - Sibling, Male, 7 Years	10242 - Mother, Female, 42 Years	Parents Drug / Alcohol Misuse	Unfounded	
	10241 - Deceased Child, Female, 13 Years	10242 - Mother, Female, 42 Years	Inadequate Guardianship	Unfounded	
	10244 - Sibling, Male, 7 Years	10242 - Mother, Female, 42 Years	Inadequate Guardianship	Unfounded	
	10244 - Sibling, Male, 7 Years	10242 - Mother, Female, 42 Years	Lack of Supervision	Unfounded	
	10241 - Deceased Child, Female, 13 Years	10242 - Mother, Female, 42 Years	Lack of Supervision	Unfounded	
	10244 - Sibling, Male, 7 Years	10242 - Mother, Female, 42 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:
Subject mother is addicted to Loratab and is impaired (non-prescription) and is impaired by it while responsible for Subject child (13) and sibling (7). SC is responsible for watching sibling for twelve hours a day. SC is not responsible enough to care for sibling and he does not listen to SC. SC cannot cook, so the children go all day without eating. They are hungry and are begging neighbors for food. SC is responsible for cleaning the house and helping sibling with his homework. Sibling runs unsupervised in the street. Recently, SC got lice from watching other children . SC is depressed due to all of her responsibilities. SM is always swearing/cursing at SC.

Determination: Unfounded	**Date of Determination:** 02/17/2016

Basis for Determination:
Through interviews with all relevant parties, collateral contacts, and home visits, it is determined that there is no credible evidence to support the allegations. The children acknowledged that SC does watch her younger sibling, but reported her older sibling, age 18, is also supervising with her while SM is at work. SM denied Loratab addiction for which she has a prescription. SM observed as sober on all drop-in home visits. Ample food supplies were observed in the home. SC has history of self-cutting, but no current such activity or depression. SM acknowledged calling child an "ungrateful bitch" on one occasion after buying clothes for SC and SC refusing to wear them.

OCFS Review Results:
No concerns are evident upong BRO OCFS review.

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

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

There is a CPS history of two prior SCR reports involving this family that are more than three years prior to the fatality incident. These two reports are both UNFOUNDED. The two reports are as follows:

09/12/2012 Allegations of Lack of Supervision against subject mother and bio-father involving subject child's youngest male sibling getting outside the home onto the neighbor's porch while the oldest sibling was supervising. The older sibling was right behind the younger child and the child was not un-supervised. Services offered and declined. UNFOUNDED 09/18/2012.

08/18/2006 Allegations of Inadequate food/clothing/shelter, Parent's drug/alcohol misuse, Excessive corporal punishment, and Inadequate guardianship against subject mother and bio-father involving bio-father's discipline of oldest male sibling. The child had no marks or bruises. Bio-father acknowledged marijuana use, but not in the presence of the children. Adequate food supplies were observed in the home. The children reported no concerns. Offered services were declined. UNFOUNDED 10/28/2006.

Known CPS History Outside of NYS

There is no known CPS history involving this family outside New York State.

Services Open at the Time of the Fatality

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?
☐Family Court ☒Criminal Court ☒Order of Protection

Criminal Charge: Endangering the welfare of a child	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
08/31/2015	bio-father	Unknown	Charges were dropped after the death of SC.
Comments:	About three months prior to the fatality, the father of subject child was arrested and an Order of Protection issued against him in favor of subject child pertaining to an incident were he was intoxicated and grabbed her arm/pushed her to the ground in a store following an argument. At the time of the fatality investigation closing, there was no disposition to the charges. The criminal charges and OOP were dropped after the death of subject child.		

Have any Orders of Protection been issued? Yes	
From: 09/01/2015	**To:** 12/13/2015
Explain: About three months prior to the fatality, the father of subject child was arrested and an Order of Protection issued against him in favor of subject child pertaining to an incident were he was intoxicated and grabbed her arm/pushed her to the ground in a store following an argument. This OOP expired and the charges were dropped upon the subject child's death	

on 12/13/2015.

Additional Local District Comments

We find that the facts describe the unfortunate events and actions taken. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality. We appreciate the opportunity to partner with OCFS in providing the best possible services to families in our community.

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