# Child Fatality Report

## Report Identification Number: SV-17-053

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

## Issue Date: May 14, 2018

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

## Abbreviations

| | | |
|---|---|---|
| **Relationships** | | |
| BM-Biological Mother | SM-Subject Mother | SC-Subject Child |
| BF-Biological Father | SF-Subject Father | OC-Other Child |
| MGM-Maternal Grand Mother | MGF-Maternal Grand Father | FF-Foster Father |
| PGM-Paternal Grand Mother | PGF-Paternal Grand Father | DCP-Day Care Provider |
| MGGM-Maternal Great Grand Mother | MGGF-Maternal Great Grand Father | PGGF-Paternal Great Grand Father |
| PGGM-Paternal Great Grand Mother | MA/MU-Maternal Aunt/Maternal Uncle | PA/PU-Paternal Aunt/Paternal Uncle |
| FM-Foster Mother | SS-Surviving Sibling | PS-Parent Sub |
| CH/CHN-Child/Children | OA-Other Adult | |
| **Contacts** | | |
| LE-Law Enforcement | CW-Case Worker | CP-Case Planner |
| Dr.-Doctor | ME-Medical Examiner | EMS-Emergency Medical Services |
| DC-Day Care | FD-Fire Department | BM-Biological Mother |
| CPS-Child Protective Services | | |
| **Allegations** | | |
| FX-Fractures | II-Internal Injuries | L/B/W-Lacerations/Bruises/Welts |
| S/D/S-Swelling/Dislocation/Sprains | C/T/S-Choking/Twisting/Shaking | B/S-Burns/Scalding |
| P/Nx-Poisoning/ Noxious Substance | XCP-Excessive Corporal Punishment | PD/AM-Parent's Drug Alcohol Misuse |
| CD/A-Child's Drug/Alcohol Use | LMC-Lack of Medical Care | EdN-Educational Neglect |
| EN-Emotional Neglect | SA-Sexual Abuse | M/FTTH-Malnutrition/Failure-to-thrive |
| IF/C/S-Inadequate Food/ Clothing/ Shelter | IG-Inadequate Guardianship | LS-Lack of Supervision |
| Ab-Abandonment | OTH/COI-Other | |
| **Miscellaneous** | | |
| IND-Indicated | UNF-Unfounded | SO-Sexual Offender |
| Sub-Substantiated | Unsub-Unsubstantiated | DV-Domestic Violence |
| LDSS-Local Department of Social Service | ACS-Administration for Children's Services | NYPD-New York City Police Department |
| PPRS-Purchased Preventive Rehabilitative Services | TANF-Temporary Assistance to Needy Families | FC-Foster Care |
| MH-Mental Health | ER-Emergency Room | COS-Court Ordered Services |
| OP-Order of Protection | RAP-Risk Assessment Profile | FASP-Family Assessment Plan |
| FAR-Family Assessment Response | Hx-History | Tx-Treatment |
| CAC-Child Advocacy Center | PIP-Program Improvement Plan | yo- year(s) old |
| CPR-Cardiopulmonary Resuscitation | | |

## Case Information

**Report Type:** Child Deceased
**Age:** 2 month(s)
**Jurisdiction:** Suffolk
**Gender:** Female
**Date of Death:** 11/23/2017
**Initial Date OCFS Notified:** 11/23/2017

### Presenting Information

An SCR report alleged the following: At approximately 4:47am on 11/23/2017, the 2-month-old female SC was found unresponsive on SM's bed. Prior to that, SM fed, changed, and put SC to sleep on the bed. SM periodically checked on the child; the last time she did, the infant was not breathing and SM initiated CPR. The infant subsequently died and was pronounced dead a short time later at the hospital. SC was otherwise healthy and did not have any known preexisting medical conditions. There were no visible signs of trauma and SM was unable to provide an explanation for the infant's death. The grandmother and five unrelated home members were made subjects of the report as they were in the home at the time of the incident and were allegedly caregivers for the SC. The SC's father and another unrelated home member were not in the home at the time of the incident and their roles were unknown. The roles of four other children, ages 17, 5, 3, and 2, were unknown.

### Executive Summary

On 11/23/2017, Suffolk County Department of Social Services (SCDSS) received a CPS report concerning the death of the SC. SCDSS initiated a joint investigation with local LE. SCDSS reviewed all CPS Hx within 24 hours, noting the location of the 8 SS (in a family residential center, in Foster Care) as well as 4 unrelated CHN in the home. SCDSS gathered pertinent information from LE before responding to the home, where the death occurred.

Seven adults were named as subjects for allegations of IG and DOA/Fatality regarding SC. SCDSS determined 3 of those adults were only visiting for the holiday. SM rented a room from a 55yo unrelated home member (referred throughout this report as UHM2). SM resided there with SC, and though SC's BF frequented, he had not been there in the days leading up to the fatality. There was familial relation between the household members, but SM and her family were not related to them. Many of the adults disclosed limited knowledge about the events leading up to the fatality, though 2 adults corroborated the timeline of events according to SM's statement.

From SM's account, SCDSS learned the last time SM saw SC alive, she placed SC to sleep on her side on the adult bed with a pillow behind her back. SM went in the other room but checked on SC periodically; the last time, SM found SC on her back, unresponsive. SM began CPR and UHM2 called 911. Upon arrival, EMS continued resuscitative measures en route to the hospital, where SC was pronounced deceased at 5:31AM. LE relayed the ME did not find trauma to SC, who appeared otherwise healthy and hydrated. SCDSS requested the hospital records and autopsy report, though the report was not complete at the time the investigation closed and the hospital records had not been received. SCDSS later contacted the ME regarding the report's completion for the purpose of providing information for this fatality report, and although the report was complete, the ME was unable to share it until permitted to do so by the District Attorney. There was no record of any arrest related to the fatality.

SCDSS completed timely safety assessments and interviewed the 3 youngest OC in the home within 24 hours, assessing them as safe (ages 5, 3, and 2, referred throughout this report as OC2, OC3, and OC4). Neither they nor their parents, who lived in a room in the upstairs portion of the home, had any knowledge about the incident or any other useful information about the SM and SC in general. Efforts were made to assess 24-hour safety of the 17yo OC (who was a relative of UHM2 and in her custody, referred throughout this report as OC1). OC1 was later interviewed on 11/27/17, and no safety concerns were noted.

SCDSS had provided a portable crib around the time the SC was born, but it was not being used. SM reported she was

aware of safe sleep practices and had not placed the SC on her stomach to sleep, nor did she find the SC face-down or with anything obstructing her airway. SCDSS found no evidence that the sleep environment contributed to the SC's death. There was credible reasoning to believe the rest of the subjects were not legally responsible for SC, even though SCDSS did not document efforts to interview 2 of the alleged subjects beyond the initial home visit. For these reasons, all allegations were Unsub.

The 8 SS were in FC at the time of SC's death for reasons unrelated to the fatality. At the time of SC's birth, SM had completed all services and needed only to obtain housing sufficient to house all 9 CHN. After the SS learned of SC's death, they were provided counseling and support. SM was provided information on bereavement services and assistance with funeral finances. SCDSS made diligent efforts to engage the SM and SF during the investigation. The investigation was closed and UNF, while the SM and SS remained active in the open FC case.

**PIP Requirement**

SCDSS will submit a PIP to the Spring Valley Regional Office within 30 days of receipt of this report. The PIP will identify action(s) SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS 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?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

**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:**

The 24-hour safety assessment noted there were no safety factors; however, 8 of the SS were in Foster Care at the time of the fatality. The safety decision should have been noted as a Safety Decision #4, continued placement in Foster Care; without this safety intervention (which was in place) the children would not have been protected.

**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:**
Casework activity was commensurate with case circumstances and the decision to close the case was appropriate.

**Required Actions Related to the Fatality**

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

| | |
|---|---|
| **Issue:** | Adequacy of Documentation of Safety Assessments |
| **Summary:** | The 24-hour Safety Assessment noted a Safety Decision #1 (no safety factors), despite the surviving siblings on the case remaining in Foster Care as a controlling intervention for ongoing concerns. |
| **Legal Reference:** | 18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b) |
| **Action:** | When children are in Foster Care and continued placement is necessary, a Safety Decision #4 must be selected to reflect the current safety of the children, as this reflects the safety interventions currently in place. The focus of the Safety Assessment in a Child Welfare Services case is always the children's family/home of origin. |
| | |
| **Issue:** | Failure to provide notice of report |
| **Summary:** | Though all of the adults in the home and parents of the surviving children were notified of the report, there is no documentation that any of the parents of the other children named were notified in writing. |
| **Legal Reference:** | 18 NYCRR 432.2(b)(3)(ii)(f) |
| **Action:** | SCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report. |
| | |
| **Issue:** | Adequacy of Risk Assessment Profile (RAP) |
| **Summary:** | The RAP failed to note that the children had been in placed in Foster Care twice prior to this report date. The Elevated Risk Factor to reflect that they remained in Foster Care was also not selected, greatly skewing the score. |
| **Legal Reference:** | 18 NYCRR 432.2(d) |
| **Action:** | SCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile. |
| | |

## Fatality-Related Information and Investigative Activities

**Incident Information**

**Date of Death:** 11/23/2017 **Time of Death:** 05:31 AM

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

**County where fatality incident occurred:** Suffolk
**Was 911 or local emergency number called?** Yes

# Child Fatality Report

**Time of Call:** 04:47 AM
**Did EMS respond to the scene?** Yes
**At time of incident leading to death, had child used alcohol or drugs?** No
**Child's activity at time of incident:**

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

**Did child have supervision at time of incident leading to death?** Yes
**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
**Adults:** 0

**Household Composition at time of Fatality**

| Household | Relationship | Role | Gender | Age |
|---|---|---|---|---|
| Deceased Child's Household | Deceased Child | Alleged Victim | Female | 2 Month(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 32 Year(s) |
| Deceased Child's Household | Other Child - Child of whom UHM2 has legal custody | No Role | Female | 17 Year(s) |
| Deceased Child's Household | Other Child - OC3 | No Role | Male | 3 Year(s) |
| Deceased Child's Household | Other Child - OC4 | No Role | Female | 2 Year(s) |
| Deceased Child's Household | Other Child - OC2 | No Role | Female | 5 Year(s) |
| Deceased Child's Household | Unrelated Home Member | Alleged Perpetrator | Female | 63 Year(s) |
| Deceased Child's Household | Unrelated Home Member | Alleged Perpetrator | Male | 20 Year(s) |
| Deceased Child's Household | Unrelated Home Member | Alleged Perpetrator | Female | 55 Year(s) |
| Deceased Child's Household | Unrelated Home Member | Alleged Perpetrator | Male | 25 Year(s) |
| Other Household 1 | Other Adult - Unrelated adult, visiting home | No Role | Female | 55 Year(s) |
| Other Household 2 | Unrelated Home Member | Alleged Perpetrator | Female | 52 Year(s) |
| Other Household 3 | Other Adult - 16yo SS's BF | No Role | Male | 46 Year(s) |
| Other Household 4 | Father | No Role | Male | 43 Year(s) |
| Other Household 5 | Other Adult - SS's BF | No Role | Male | 35 Year(s) |

| | | | | |
|---|---|---|---|---|
| Other Household 6 | Other Adult - Unrelated adult, visiting home | Alleged Perpetrator | Female | 23 Year(s) |
| Other Household 7 | Sibling | No Role | Female | 7 Year(s) |
| Other Household 7 | Sibling | No Role | Male | 12 Year(s) |
| Other Household 7 | Sibling | No Role | Male | 15 Year(s) |
| Other Household 7 | Sibling | No Role | Male | 15 Year(s) |
| Other Household 7 | Sibling | No Role | Male | 16 Year(s) |
| Other Household 7 | Sibling | No Role | Male | 10 Year(s) |
| Other Household 7 | Sibling | No Role | Female | 9 Year(s) |
| Other Household 7 | Sibling | No Role | Male | 7 Year(s) |

## LDSS Response

On 11/23/17 after gathering pertinent information from LE who had already responded to the home, SCDSS made a home visit in effort to speak with all persons in the residence. SCDSS was informed by an unidentified female that the SM was not home. Persons in the residence on that date would not answer any questions surrounding the incident, and they would not identify themselves. Later that night, SCDSS made a home visit and interviewed the family living in the upstairs of the home (UHM2's son, his 3 CHN, and their mother). SCDSS held interviews with those 5 family members and discovered no concerns for those children; further, the adults had no information to share about SM or the SC, or the fatality. SCDSS also interviewed the 17yo CH (OC1) and assessed her to be safe as well. SCDSS documented the 8 SS were protected, as they were residing in a family residential Foster Home.

SCDSS conducted face-to-face interviews with all household members, except for UHM2's 20yo son who reportedly had a mental disability; however, he too was named a subject and documentation did not reflect reasons why an interview was not possible. Three other adults, 2 named as subjects and 1 not, were identified as not residing in the home and were visiting at the time of the SC's death. One was interviewed face-to-face, the other was interviewed by phone as she had returned to her home out of state, and there was no documentation to reflect efforts to interview the other beyond the initial attempt at contact with all persons named in the home on the report. The BF was seen on more than one occasion, both in the home and later in jail when he was arrested (for reasons unrelated to the fatality), though he refused to cooperate in any interviews. Though SC's BF frequented the home, he had not been there in the days leading up to the fatality.

SCDSS observed the SM's room where SC was found unresponsive, and found no separate sleeping environment for SC. SM recounted the events leading up to the time she found SC unresponsive, and provided a statement to LE. SM reported she left the home around 2AM on 11/23/2017 to buy cigarettes at a nearby store, and left the sleeping infant on her back on her adult bed, supervised by OC1. When SM returned 15-20 minutes later, she observed the SC alive, laid her on her side with a pillow behind her back, then went into the living room to visit with the other adults in the home. OC1 corroborated information about the short amount of time she watched the SC in SM's absence, at which point she had laid on the bed next to her. OC1 also heard the SC cry when she left the room upon SM's return, confirming the SC was alive at that time. SM stated that while she visited with the other adults in the home, she had a couple beers but was not intoxicated. SM checked on the SC a couple hours later and found her unresponsive. She screamed and began CPR; UHM2 heard the commotion and called 911 at 4:47AM. Upon their arrival, EMS continued resuscitative measures en route to the hospital, where the SC arrived with no heartbeat and was pronounced deceased.

First responders noted they had not suspected SM was impaired by drugs or alcohol, and other home members reported this as well. It was not apparent the SC was taking any medications in the time leading up to her death. SCDSS learned the 4 OC who resided in the home were asleep at the time of the incident, as well as other adults named in the report, and thus had no knowledge of events leading up to the fatality.

SM remained engaged in efforts to have the remaining SS returned to her care, who had been in Foster Care since March 2016 due to SM's neglect. The investigation was UNF and closed.

## Official Manner and Cause of Death

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

## Multidisciplinary Investigation/Review

**Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?**Yes

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?**No
**Comments:** There is no Child Fatality Review Team in Suffolk County.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 045620 - Deceased Child, Female, 2 Mons | 045621 - Mother, Female, 32 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045727 - Unrelated Home Member, Male, 20 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045623 - Unrelated Home Member, Female, 55 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045621 - Mother, Female, 32 Year(s) | DOA / Fatality | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045622 - Unrelated Home Member, Female, 63 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045727 - Unrelated Home Member, Male, 20 Year(s) | DOA / Fatality | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045726 - Other Adult - Unrelated adult, visiting home, Female, 23 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045622 - Unrelated Home Member, Female, 63 Year(s) | DOA / Fatality | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045725 - Unrelated Home Member, Male, 25 Year(s) | DOA / Fatality | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045726 - Other Adult - Unrelated adult, visiting home, Female, 23 Year(s) | DOA / Fatality | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045623 - Unrelated Home Member, Female, 55 Year(s) | DOA / Fatality | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045725 - Unrelated Home Member, Male, 25 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 045620 - Deceased Child, Female, 2 Mons | 045721 - Unrelated Home Member, Female, 52 Year(s) | DOA / Fatality | Unsubstantiated |

| | | | |
|---|---|---|---|
| 045620 - Deceased Child, Female, 2 Mons | 045721 - Unrelated Home Member, Female, 52 Year(s) | Inadequate Guardianship | 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?** | ☐ | ☒ | ☐ | ☐ |
| Emergency Room Personnel | ☐ | ☒ | ☐ | ☐ |
| **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:**
Efforts were made to obtain hospital records, but they were not received. Efforts were made to interview others persons named and all subjects face-to-face.

## 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?** | ☒ | ☐ | ☐ | ☐ |

**Explain:**
Although SCDSS adequately assessed safety of the CHN within 24 hours, the 24-hour Safety Assessment incorrectly documented there were noted no safety factors, despite the SS remaining in Foster Care. If the Safety Assessment were accurately documented, a Safety Decision #4 would have been selected to reflect the need for continued placement.

## Fatality Risk Assessment / Risk Assessment Profile

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

**Explain:**
The RAP failed to note that the children had been in placed in Foster Care twice prior to this report date. The Elevated Risk Factor to reflect that they remained in Foster Care was also not selected, greatly skewing the score.

## 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:**
The 8 SS remained in Foster Care, as they had since 2016. There was no need for the 4 OC in the home to be removed.

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

**Additional information, if necessary:**
The SS are presently in counseling, and SM was provided with bereavement referrals (unknown if used). Several services were provided to SM but completed at the time of the fatality in order to address the SS still in care. Housing assistance was being explored in the open Services case, as it was what was needed to get the SS to return to SM's care.

**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:**
Staff at the residential center where the SS resided provided counseling and support regarding the fatality, and the Case Planner provided additional support before, during and after funeral services. Documentation does not reflect that the other children in the home were offered services.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
SM and SF were the only caregivers of the SC. They were offered bereavement services, but it is not apparent that any were utilized during the investigation; however, SM continued to receive support in the open Services case.

## History Prior to the Fatality

### Child Information

**Did the child have a history of alleged child abuse/maltreatment?** No
**Was there an open CPS case with this child at the time of death?** No
**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?** Yes
**Was the child acutely ill during the two weeks before death?** No

### Infants Under One Year Old

**During pregnancy, mother:**

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

**Infant was born:**

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

## 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) |
|---|---|---|---|---|---|
| 10/04/2017 | Other Child - OC2, Female, 4 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Inadequate Food / Clothing / Shelter | Unfounded | Yes |
| | Other Child - OC2, Female, 4 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC3, Male, 3 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Other Child - OC4, Female, 2 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC2, Female, 4 Years | Unrelated Home Member, Female, 55 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Other Child - OC3, Male, 3 Years | Unrelated Home Member, Female, 55 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Other Child - OC3, Male, 3 Years | Unrelated Home Member, Female, 55 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC4, Female, 2 Years | Unrelated Home Member, Female, 55 Years | Inadequate Food / Clothing / Shelter | Unfounded | |

| | | | |
|---|---|---|---|
| Other Child - OC2, Female, 4 Years | Other Adult - BF of OC2, OC3, OC4, Male, 23 Years | Inadequate Food / Clothing / Shelter | Unfounded |
| Other Child - OC4, Female, 2 Years | Other Adult - BF of OC2, OC3, OC4, Male, 23 Years | Inadequate Food / Clothing / Shelter | Unfounded |
| Other Child - OC4, Female, 2 Years | Other Adult - BF of OC2, OC3, OC4, Male, 23 Years | Inadequate Guardianship | Unfounded |
| Other Child - OC3, Male, 3 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Parents Drug / Alcohol Misuse | Unfounded |
| Other Child - OC2, Female, 4 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Lack of Medical Care | Unfounded |
| Other Child - OC2, Female, 4 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Poisoning / Noxious Substances | Unfounded |
| Other Child - OC3, Male, 3 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Inadequate Guardianship | Unfounded |
| Other Child - OC4, Female, 2 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Inadequate Food / Clothing / Shelter | Unfounded |
| Other Child - OC2, Female, 4 Years | Unrelated Home Member, Female, 55 Years | Inadequate Guardianship | Unfounded |
| Other Child - OC4, Female, 2 Years | Unrelated Home Member, Female, 55 Years | Inadequate Guardianship | Unfounded |
| Other Child - OC2, Female, 4 Years | Other Adult - BF of OC2, OC3, OC4, Male, 23 Years | Inadequate Guardianship | Unfounded |
| Other Child - OC3, Male, 3 Years | Other Adult - BF of OC2, OC3, OC4, Male, 23 Years | Inadequate Food / Clothing / Shelter | Unfounded |
| Other Child - OC3, Male, 3 Years | Other Adult - BF of OC2, OC3, OC4, Male, 23 Years | Inadequate Guardianship | Unfounded |
| Other Child - OC2, Female, 4 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Parents Drug / Alcohol Misuse | Unfounded |
| Other Child - OC4, Female, 2 Years | Other Adult - BM of OC2, OC3, OC4, Female, 24 Years | Parents Drug / Alcohol Misuse | Unfounded |

**Report Summary:**
SCR report concerned the 3 youngest CHN in the home at the time of the fatality (OC2, OC3, and OC4) against their parents and PGM (UHM2). It was alleged the BM became impaired by a drug while caring for the CHN, and the BF sold the drug from the home. In summer 2017, OC2, age 4, accessed and swallowed the drug while in the care of the parents. OC2 became very ill and required hospitalization. The PGM was aware of the drug sales and use in the presence of the CHN but did not intervene to protect them. A subsequent report received 10/15/17 was similar but added BM also sold the drugs and the home was deplorable with no food in the home. The CHN were not provided appropriate clothing.

**Determination:** Unfounded | **Date of Determination:** 12/13/2017

**Basis for Determination:**
SCDSS found all parties denied the allegations. They shared OC2 did ingest something unknown over the summer at a bar-b-que which made her ill, and they sought medical attention. They reported this was previously investigated. SCDSS observed the CHN appeared cared for and did not find evidence to substantiate any of the allegations.

**OCFS Review Results:**
SCDSS addressed the allegations by speaking with the family and observing the home; however, the case was closed before information was documented concerning the alleged incident over the summer. The family reported it was

previously investigated and that OC2 received medical care, but no medical information was received and information was not documented as to whether this was in fact previously investigated.

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

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

**Summary:**
SCDSS closed the case prior to fully investigating certain allegations in the report. No collateral information was recorded to verify the parents' claim surrounding the alleged serious incident over the summer.

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

**Action:**
SCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 08/23/2017 | Sibling, Male, 7 Years | Father, Male, 43 Years | Inadequate Guardianship | Unfounded | Yes |
| | Sibling, Male, 14 Years | Mother, Female, 32 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 16 Years | Mother, Female, 32 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 10 Years | Mother, Female, 32 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Female, 7 Years | Mother, Female, 32 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 7 Years | Mother, Female, 32 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 11 Years | Mother, Female, 32 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Female, 7 Years | Father, Male, 43 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Female, 9 Years | Mother, Female, 32 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 14 Years | Mother, Female, 32 Years | Inadequate Guardianship | Unfounded | |

**Report Summary:**
SCR report alleged on 8/20/2017, the 8 children in Foster Care were visiting with SM and SF when the 14yo SS was allowed to get into the family's vehicle. The child backed out of the driveway and stopped halfway out into the road and was almost hit by an oncoming truck. When the child pulled the car back in the driveway, SM and SF were not paying attention to the other SS who were running towards the car; the SS almost hit his siblings with the car as a result. SF was only a person legally responsible for his 2 CHN; therefore, he was only a subject regarding them.

**Determination:** Unfounded | **Date of Determination:** 09/28/2017

**Basis for Determination:**
The alleged incident took place at the children's residential foster home facility. SCDSS viewed a video tape of the incident that did not show the incident as alleged. The staff member was also present and admittedly took no effort to intervene even though she was charged with supervising the visit, though this incident was not reported to the Justice Center. The investigation found no evidence that SM was even close enough to the situation where she could have taken any action to correct the SS's behavior; further, SF was not present at the visit.

**OCFS Review Results:**
SCDSS conducted a thorough investigation into the allegations of the report. Two of the biological fathers were not notified of the report. The safety assessments inaccurately reflected there were no safety factors, despite the children currently being in Foster Care. SCDSS did not document a safe sleep discussion with the parents of the infant (SC) who was born during the open investigation. The Spring Valley Regional Office (SVRO) was made aware of the above-

mentioned incident concerning the supervised visit, which had not been reported to the Justice Center, and SVRO is addressing the matter with the agency.

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

**Issue:**
Adequacy of Documentation of Safety Assessments
**Summary:**
Both assessments inaccurately reflected there were no safety factors, despite the children currently being in Foster Care.
**Legal Reference:**
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
**Action:**
When children are in Foster Care and continued placement is necessary, a Safety Decision #4 must be selected to reflect the current safety of the children, as this reflects the safety interventions currently in place. The focus of the Safety Assessment in a Child Welfare Services case is always the children's family/home of origin.

**Issue:**
Failure to provide notice of report
**Summary:**
Two of the biological fathers were not notified of the report.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
SCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

**Issue:**
Failure to provide safe sleep education/information
**Summary:**
SCDSS did not document providing the parents with safe sleep information for the infant (SC) who was born during the open investigation.
**Legal Reference:**
13-OCFS-ADM-02
**Action:**
SCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 06/17/2017 | Other Child - OC2, Female, 4 Years | Other Adult - BM of OC2, OC3, OC4, Female, 23 Years | Inadequate Guardianship | Unfounded | Yes |
| | Other Child - OC2, Female, 4 Years | Other Adult - BM of OC2, OC3, OC4, Female, 23 Years | Lack of Supervision | Unfounded | |
| | Other Child - OC2, Female, 4 Years | Other Adult - BF of OC2, OC3, OC4, Male, 23 Years | Lack of Supervision | Unfounded | |
| | Other Child - OC2, Female, 4 Years | Other Adult - BF of OC2, OC3, OC4, Male, 23 Years | Inadequate Guardianship | Unfounded | |

**Report Summary:**
SCR report concerned the other child in the home at the time of the fatality (OC2) against her parents. The report alleged OC2, age 4, exhibited symptoms consistent with the ingestion of a narcotic, though the narcotic toxicology screening was negative. The explanations given by her BM and BF were inconsistent, and there were concerns about the level of supervision for the child. A subsequent report received on 6/19/17 alleged the same but noted OC2 tested positive for amphetamines.

**Determination:** Unfounded | **Date of Determination:** 09/13/2017

**Basis for Determination:**
SCDSS learned the family attended a birthday party in the park, where the incident was likely to have taken place based on the timing of OC2's presenting symptoms. SCDSS interviewed OC2 and when asked what made her sick she said something about “daddy’s juice,” but would not elaborate. SCDSS concluded there was no evidence to support the allegations, and noted no indication that the family members were drug involved or that the child had access to drugs at home. It was noted it was unclear exactly what the child ingested or where she got it from, that it was an isolated incident, and appeared to have been an accident.

**OCFS Review Results:**
Nassau County CPS responded in 24-hours based on location of family in hospital and during interviews, did not suspect parental impairment. SCDSS also interviewed the family, and although they were repeatedly asked if they knew how OC2 could have ingested anything, no one was questioned about the level of supervision at the incident location. Asking about this aspect as well as attempting to interview any available children and/or adults at the party would have provided essential information as to the allegations.

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

**Issue:**
Determination of Nature, Extent and Cause of Conditions (Report)

**Summary:**
The allegation concerning supervision was not adequately explored. Addressing the topic with the family and contacting additional collateral contacts was an essential part of the investigation into this allegation. Without information to the contrary, there appeared to have been some credible evidence to substantiate this allegation.

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

**Action:**
SCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations, as well as address all such topics with the family, subjects, and children.

**Issue:**
Appropriateness of allegation determination

**Summary:**
Based on the limited information surrounding what occurred at the incident location, there was credible evidence to substantiate that the young child was not adequately supervised such that she was able to ingest a toxic substance without either caregiver noticing. The parents were not questioned about the level of supervision.

**Legal Reference:**
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

**Action:**
SCDSS will fully explore each allegation and take into consideration all information gathered when applying the circumstances to the definitions.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| 01/05/2017 | Sibling, Male, 14 Years | Mother, Female, 31 Years | Inadequate Guardianship | Unfounded | Yes |
| | Sibling, Male, 11 Years | Mother, Female, 31 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Female, 8 Years | Mother, Female, 31 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Female, 6 Years | Mother, Female, 31 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Female, 6 Years | Mother, Female, 31 Years | Burns / Scalding | Unfounded | |
| | Sibling, Male, 6 Years | Mother, Female, 31 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 6 Years | Mother, Female, 31 Years | Burns / Scalding | Unfounded | |
| | Sibling, Male, 15 Years | Mother, Female, 31 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 9 Years | Mother, Female, 31 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 11 Years | Mother, Female, 31 Years | Burns / Scalding | Unfounded | |
| | Sibling, Female, 8 Years | Mother, Female, 31 Years | Burns / Scalding | Unfounded | |

**Report Summary:**
SCR report alleged the 15, 14, 11, 9, 8, and 6yo twins all had healed scars on their bodies. It was noted several of them were from seemingly inflicted burns, and were suspicious in nature. The explanations provided were inconsistent for the injuries sustained. All of the CHN were in the care of the SM during the time the injuries occurred. Roles of the 3 BF's were unknown.

**Determination:** Unfounded | **Date of Determination:** 04/13/2017

**Basis for Determination:**
The 7 SS were in Foster Care at the time of this report, since March 2016. Though the investigation noted the children were observed to be free of all burns, marks and bruises, case notes documented 5 of the children had "old scars;" however, none of the children reported the injuries were caused by SM. The conclusion noted the allegations had been previously investigated as well.

**OCFS Review Results:**
There was no collateral contact with any medical professional, even though one of the children refused to speak or allow observation of the areas of the body where injuries were alleged. Documentation did not explicitly note injuries or lack thereof in all areas of the body alleged on all of the children named as subject children. The safety assessments inaccurately reflected there were no safety factors, despite the children currently being in Foster Care. There were inconsistencies in the RAP. There was no attempt to interview the biological fathers, who were named on the report.

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

**Issue:**
Adequacy of Documentation of Safety Assessments
**Summary:**
Both assessments inaccurately reflected there were no safety factors, despite the children currently being in Foster Care.
**Legal Reference:**
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
**Action:**
When children are in Foster Care and continued placement is necessary, a Safety Decision #4 must be selected to reflect the current safety of the children, as this reflects the safety interventions currently in place. The focus of the Safety Assessment in a Child Welfare Services case is always the children's family/home of origin.

**Issue:**
Contact/Information From Reporting/Collateral Source
**Summary:**
Despite the nature of the allegations and the credibility of the source, no information was sought from any medical professional. None of the biological fathers were attempted to be interviewed, although they were named in the report. Their roles were changed to "reported in error" prior to closing the investigation.
**Legal Reference:**

18 NYCRR 432.2(b)(3)(ii)(b)

**Action:**

SCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

**Issue:**

Adequacy of Risk Assessment Profile (RAP)

**Summary:**

The RAP inaccurately reflected no DV or MH history of the SM, despite recent history documenting the contrary, as well as noting there was no history of children being in the care of alternate caregivers (the children were currently in Foster Care and had been in Foster Care once prior, as well).

**Legal Reference:**

18 NYCRR 432.2(d)

**Action:**

SCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 07/20/2016 | Other Child - OC3, Male, 2 Years | Unrelated Home Member, Female, 54 Years | Inadequate Guardianship | Far-Closed | Yes |
| | Other Child - OC1, Female, 15 Years | Unrelated Home Member, Female, 54 Years | Childs Drug / Alcohol Use | Far-Closed | |

**Report Summary:**

SCR report concerned the eldest other child in the home at the time of the fatality (OC1) with allegations against her aunt/custodian (UHM2). Report alleged UHM2 gave one of her prescribed narcotic pills to the child for the child's headache and to make her sleep. OC1 was not prescribed the medication and she did fall asleep. OC1's brother had an unknown role. A subsequent report received 8/30/16 alleged UHM2 failed to provide adequate hygiene to her 2yo grandson (OC3), who had multiple untreated bug bites which were infected.

**OCFS Review Results:**

SCDSS engaged the family and learned OC1 had found a pill on UHM2's dresser and thinking it was Tylenol, took it for a headache without asking anyone. OC1 reported she then took a nap and woke up without complications. SCDSS spoke with collaterals provided by the family and confirmed her grandson was being adequately treated medically for his skin condition. Engagement between family members and SCDSS was well-documented as well as a listing of strengths and concerns that were addressed.

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

**Issue:**

FAR-Failure to Provide Notice of Report

**Summary:**

The parents of OC1 and her sibling were never notified of the report.

**Legal Reference:**

18 NYCRR 432.13 (e)(2)(i)(a)-(d)

**Action:**

No later than seven days after receipt of a child protective report that has been assigned to the family assessment response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 02/11/2016 | Other Child - OC1, Female, 15 Years | Unrelated Home Member, Female, 53 Years | Lack of Supervision | Unfounded | Yes |
| | Other Child - OC1's brother, Male, 12 Years | Unrelated Home Member, Female, 53 Years | Lack of Supervision | Unfounded | |
| | Other Child - OC1, Female, 15 Years | Other Adult - OC1's step-mother, Female, 43 Years | Lack of Supervision | Unfounded | |
| | Other Child - OC1's brother, Male, 12 Years | Other Adult - OC1's step-mother, Female, 43 Years | Lack of Supervision | Unfounded | |
| | Other Child - OC1's brother, Male, 12 Years | Unrelated Home Member, Female, 53 Years | Lacerations / Bruises / Welts | Unfounded | |
| | Other Child - OC1, Female, 15 Years | Unrelated Home Member, Female, 53 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC1's brother, Male, 12 Years | Unrelated Home Member, Female, 53 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC1, Female, 15 Years | Other Adult - OC1's step-mother, Female, 43 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC1's brother, Male, 12 Years | Other Adult - OC1's step-mother, Female, 43 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC1's brother, Male, 12 Years | Other Adult - OC1's step-mother, Female, 43 Years | Lacerations / Bruises / Welts | Unfounded | |

**Report Summary:**
SCR report concerned the eldest other child in the home at the time of the fatality (OC1) and her brother (then ages 14 and 12), with allegations against their aunt/custodian (UHM2) and step-mother (PS). It was alleged UHM2 and the PS allowed the children to fight and on 2/10/16, OC1 stabbed her brother with a pocket knife. The sibling required medical attention for lacerations.

**Determination:** Unfounded | **Date of Determination:** 04/21/2016

**Basis for Determination:**
SCDSS interviewed the family and contacted collaterals, concluding UHM2 was asleep when the CHN got into a physical altercation and OC1 stabbed her brother on his elbow and knee. UHM2 called the police; OC1 was taken to the precinct and her brother was brought to the hospital. Both children were being monitored by probation and receiving therapy and case management services. UHM2 was appropriate in calling police and seeking medical care, and it was determined this was an isolated incident with no similar altercations in the children's history. PS was not present for the incident. A court-ordered investigation was ordered and submitted 2/19/16.

**OCFS Review Results:**
SCDSS followed up with pertinent collateral contacts and interviewed the family, but did not notify the children's parents. SCDSS completed the court-ordered investigation and kept in touch with the family as to family interaction improvements following the incident. Review of documentation noted non-contemporaneous progress notes and an error in the RAP.

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

**Issue:**
Failure to provide notice of report

**Summary:**

None of the parents were provided Notice of Existence letters.

**Legal Reference:**

18 NYCRR 432.2(b)(3)(ii)(f)

**Action:**

SCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

**Issue:**

Adequacy of Risk Assessment Profile (RAP)

**Summary:**

The RAP inaccurately reflected the children had never been in the care of substitute caregivers, though they were currently in the custody of UHM2, their aunt, and not their parents as they were prior.

**Legal Reference:**

18 NYCRR 432.2(d)

**Action:**

SCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

**Issue:**

Timely/Adequate Case Recording/Progress Notes

**Summary:**

The progress notes were not contemporaneously entered. All notes were entered on the date the case closed, several being entered 1-2 months after the event date.

**Legal Reference:**

18 NYCRR 428.5

**Action:**

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded, as required by regulation.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 12/21/2015 | Sibling, Female, 7 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | Yes |
| | Sibling, Female, 5 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 13 Years | Mother, Female, 30 Years | Educational Neglect | Indicated | |
| | Sibling, Female, 7 Years | Mother, Female, 30 Years | Educational Neglect | Indicated | |
| | Sibling, Male, 14 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 13 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 10 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 8 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 5 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 14 Years | Mother, Female, 30 Years | Educational Neglect | Indicated | |
| | Sibling, Male, 14 Years | Mother, Female, 30 Years | Lack of Medical Care | Indicated | |

**Report Summary:**

SCR report alleged the 14yo SS, who was in a residential setting for truant and incorrigible behaviors, was not able to receive recommended MH medication due to SM's unwillingness to consent. As a result, the child was reportedly withdrawn and with flat affect. SM also refused to sign necessary releases to address the child's issues and develop a

comprehensive treatment plan. Because of SM's noncompliance, the SS was to be released from the program. A subsequent report was received on 1/5/16 alleging 4 CHN had excessive absences from school and exhibited poor hygiene on a regular basis. The 13yo SS ran away during school, his whereabouts unknown, and SM did not file a Missing Persons Report.

**Determination:** Indicated | **Date of Determination:** 03/07/2016

**Basis for Determination:**
During this investigation, neglect was established against SM and the Judge ordered removal of the CHN. SM failed provide adequate guardianship and facilitate the school attendance of the school-aged children. SM was aggressive toward SW while the CHN were in proximity; DV between SM and a PS who frequented or resided in the home was also alleged. One of the younger CHN had an untreated medical condition and another CH had poor hygiene. SM had apparent, untreated MH issues evidenced by her behavior. The allegation of LM was Unsub as SM did sign the necessary paperwork for the SS to receive medication but the SS was noncompliant. Further, it was a medication that SM had the right to decline.

**OCFS Review Results:**
SCDSS completed a thorough investigation and acted appropriately in protecting the children when circumstances arose. SCDSS did not document efforts to notify or contact any of the biological fathers during the investigation, before or after removal of the children. The RAP failed to note that the children had been in Foster Care prior to this report date. The 7-day Safety Assessment was 6 days late.

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

**Issue:**
Failure to provide notice of report
**Summary:**
SCDSS did not document efforts to notify or contact any of the biological fathers during the investigation. The children were removed and it was not documented that efforts were made to notify them of that as well, or involve them in any planning.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report.

**Issue:**
Adequacy of Risk Assessment Profile (RAP)
**Summary:**
The RAP failed to note that the children had been in Foster Care prior to this report date.
**Legal Reference:**
18 NYCRR 432.2(d)
**Action:**
SCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

**Issue:**
Timely/Adequate Seven Day Assessment
**Summary:**
The 7-day Safety Assessment was 6 days late.
**Legal Reference:**
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
**Action:**

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 11/24/2015 | Sibling, Male, 13 Years | Mother, Female, 30 Years | Inadequate Guardianship | Unfounded | Yes |
| | Sibling, Female, 5 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Sibling, Male, 8 Years | Mother's Partner, Male, 25 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Female, 7 Years | Mother, Female, 30 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 13 Years | Mother's Partner, Male, 25 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Sibling, Female, 7 Years | Mother's Partner, Male, 25 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 14 Years | Mother, Female, 30 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 13 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Sibling, Male, 8 Years | Mother, Female, 30 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 14 Years | Mother's Partner, Male, 25 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 8 Years | Mother's Partner, Male, 25 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Sibling, Female, 7 Years | Mother's Partner, Male, 25 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Sibling, Female, 5 Years | Mother's Partner, Male, 25 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Female, 5 Years | Mother, Female, 30 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Male, 14 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Sibling, Male, 8 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Sibling, Female, 7 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Sibling, Male, 14 Years | Mother's Partner, Male, 25 Years | Inadequate Food / Clothing / Shelter | Unfounded | |
| | Sibling, Male, 13 Years | Mother's Partner, Male, 25 Years | Inadequate Guardianship | Unfounded | |
| | Sibling, Female, 5 Years | Mother's Partner, Male, 25 Years | Inadequate Food / Clothing / Shelter | Unfounded | |

**Report Summary:**
SCR report alleged the home was unsanitary, with garbage and dog feces lining the floor and urine all over the bathroom. On 11/22/15, SM and a PS engaged in an argument. The PS became out of control and began breaking the windows of the home while the children were present, but the children were not harmed.

| **Determination:** Unfounded | **Date of Determination:** 12/04/2015 |
|---|---|

**Basis for Determination:**
SCDSS noted in the investigation conclusion that their interviews with SM, PS, and the SS resulted in denial of the alleged argument/incident; however, not all of the children were interviewed about such and no collaterals were contacted. SCDSS observed the home and found no notable health or safety issues.

**OCFS Review Results:**
SCDSS closed the investigation prior to interviewing and seeing all children named in the report, or contacting any collaterals. None of the biological fathers were notified of the report or interviewed, and the PS in the home was not provided a Notice of Existence letter as well. The RAP had questions answered incorrectly based on information known at that time.

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

**Issue:**
Face-to-Face Interview (Subject/Family)
**Summary:**
All of the children were not seen, and most were not interviewed. The three biological fathers were not attempted to be contacted as well.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(a)
**Action:**
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

**Issue:**
Adequacy of Risk Assessment Profile (RAP)
**Summary:**
The RAP failed to note that the children had been in Foster Care prior to this report date, and also did not capture that SM was a perpetrator of threatening incidents towards other adults.
**Legal Reference:**
18 NYCRR 432.2(d)
**Action:**
SCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

**Issue:**
Contact/Information From Reporting/Collateral Source
**Summary:**
No collateral contacts were made during this investigation.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(b)
**Action:**
SCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 09/13/2015 | Other Child - OC1, Female, 14 Years | Other Adult - OC1's BM, Female, 39 Years | Inadequate Guardianship | Indicated | Yes |
| | Other Child - OC1's sibling, Male, 12 Years | Other Adult - OC1's BM, Female, 39 Years | Childs Drug / Alcohol Use | Indicated | |
| | Other Child - OC1's sibling, Male, 12 Years | Other Adult - OC1's BM, Female, 39 Years | Lack of Medical Care | Indicated | |
| | Other Child - OC1's sibling, Male, 12 Years | Other Adult - OC1's BM, Female, 39 Years | Parents Drug / Alcohol Misuse | Indicated | |
| | Other Child - OC1's sibling, Male, 12 Years | Other Adult - OC1's BM, Female, 39 Years | Inadequate Guardianship | Indicated | |

**Report Summary:**
SCR report dated 9/13/15, and subsequent report dated 9/16/15 alleged OC1's 12yo brother was maltreated by their mother, alleging she was unable to control him, was unwilling to care for him, threatened to kill him, and was impaired by drugs such that she failed to seek medical attention for him when necessary. UHM2 resided in the home but was not an alleged subject. OC1 was not initially named an allegedly maltreated child, but during the investigation, allegations were added for her against her mother.

**Determination:** Indicated **Date of Determination:** 12/10/2015

**Basis for Determination:**
SCDSS found that on 9/13/15, OC1's BM engaged in a verbal altercation with OC1's sibling and threatened to kill herself and the children with a knife. She contacted police, left the home, and did not return. Except for the initial contact, her whereabouts were unknown throughout the length of the investigation. The CHN's aunt, UHM2, resided in the home and cared for the CHN. UHM2 petitioned the Court for custody and it was obtained on or about 12/9/15. UHM2 had been caring for the CHN most of their lives. SCDSS did not find evidence to substantiate allegations of CD/A, LM and PD/AM against OC1's BM regarding OC1's brother.

**OCFS Review Results:**
SCDSS established 24-hour safety for the children with both SCR reports. SCDSS spoke with all persons on the case prior to SM leaving without return. SCDSS conferenced legal action and remained in close contact with the family while UHM2 filed for custody of the children.

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

**Issue:**
Failure to provide notice of report

**Summary:**
SCDSS did not inquire as to the whereabouts of OC1's father or notify him of the report.

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

**Action:**
SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| 09/10/2015 | Sibling, Male, 14 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Indicated | Yes |
| | Sibling, Male, 9 Years | Mother, Female, 30 Years | Lack of Supervision | Indicated | |
| | Sibling, Male, 14 Years | Mother, Female, 30 Years | Lack of Supervision | Indicated | |
| | Sibling, Male, 12 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Indicated | |
| | Sibling, Male, 9 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Female, 7 Years | Mother, Female, 30 Years | Lack of Supervision | Indicated | |
| | Sibling, Male, 9 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Indicated | |
| | Sibling, Female, 7 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 14 Years | Mother, Female, 30 Years | Educational Neglect | Indicated | |
| | Sibling, Male, 12 Years | Mother, Female, 30 Years | Educational Neglect | Indicated | |
| | Sibling, Male, 14 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 12 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 12 Years | Mother, Female, 30 Years | Lack of Supervision | Indicated | |
| | Sibling, Female, 7 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Indicated | |
| | Sibling, Female, 5 Years | Mother, Female, 30 Years | Inadequate Food / Clothing / Shelter | Indicated | |
| | Sibling, Female, 5 Years | Mother, Female, 30 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Female, 5 Years | Mother, Female, 30 Years | Lack of Supervision | Indicated | |

**Report Summary:**
SCR report alleged SM failed to provide the SS (ages 5-14) with adequate supervision, leaving them alone for extended periods of time during the night. The SS were often outside the home or wandering around the neighborhood late at night. There was no food in the home and the SS relied on neighbors for meals. The home was unsanitary with garbage and piles of clothes throughout, and the SS were regularly filthy and unkempt. A subsequent report on 9/18/15 alleged the 12yo SS's attendance issues were negatively affecting his academics; this was known by SM, but she took no action.

**Determination:** Indicated | **Date of Determination:** 12/04/2015

**Basis for Determination:**
SM was unable and/or unwilling to address her apparent MH condition and exhibited behavior that was unstable and aggressive. She withheld the 14yo SS from the first 44 days of school, and the 12yo from the first 36 days of school, negatively impacting their grades. SM refused to address the attendance issues. SM failed to supply the SS with clean clothes and proper hygiene, or ensure they received adequate medical care. She was not abiding by the COS which were

in place per her consented entry of child neglect dated 4/26/13. This case was opened for COS which was issued on 11/19/15, at which point an EdN petition was filed and more COS were ordered.

**OCFS Review Results:**
SCDSS completed a thorough investigation into the allegations and assisted SM with housing and Social Security applications, and obtaining transportation, furniture and school supplies. SCDSS diligently filed an Educational Neglect petition against SM when circumstances warranted such action.

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

**Issue:**
Failure to provide notice of report
**Summary:**
There was no documentation that any Notice of Existence letters were provided to SM or the three biological fathers.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
SCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

**Issue:**
Face-to-Face Interview (Subject/Family)
**Summary:**
Two biological fathers who were named on the report were not attempted to be contacted.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(a)
**Action:**
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects. Such interviews or reasons why an interview was not possible should be documented in progress notes.

**Issue:**
Adequacy of Risk Assessment Profile (RAP)
**Summary:**
The RAP did not note that the children had been in Foster Care prior to this report date, and also did not capture that SM was a perpetrator of threatening incidents toward other adults (such behaviors were documented as occurring in this investigation).
**Legal Reference:**
18 NYCRR 432.2(d)
**Action:**
SCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

**Issue:**
Timely/Adequate Seven Day Assessment
**Summary:**
The 7-day Safety Assessment was 5 days late.
**Legal Reference:**
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
**Action:**
SCDSS will complete all safety assessments in the timeframes established by statute/law/regulation.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 05/06/2015 | Other Child - OC1, Female, 14 Years | Other Adult - UHM2, Female, 52 Years | Childs Drug / Alcohol Use | Unfounded | Yes |
| | Other Child - OC1, Female, 14 Years | Other Adult - UHM2, Female, 52 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC1, Female, 14 Years | Other Adult - UHM2, Female, 52 Years | Parents Drug / Alcohol Misuse | Unfounded | |
| | Other Child - UHM2's nephew, Male, 15 Years | Other Adult - UHM2, Female, 52 Years | Childs Drug / Alcohol Use | Unfounded | |
| | Other Child - UHM2's nephew, Male, 15 Years | Other Adult - UHM2, Female, 52 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC1's sibling, Male, 12 Years | Other Adult - UHM2, Female, 52 Years | Childs Drug / Alcohol Use | Unfounded | |
| | Other Child - OC1's sibling, Male, 12 Years | Other Adult - UHM2, Female, 52 Years | Parents Drug / Alcohol Misuse | Unfounded | |
| | Other Child - OC1, Female, 14 Years | Other Adult - OC1's BM, Female, 39 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC1, Female, 14 Years | Other Adult - OC1's BM, Female, 39 Years | Parents Drug / Alcohol Misuse | Unfounded | |
| | Other Child - UHM2's nephew, Male, 15 Years | Other Adult - OC1's BM, Female, 39 Years | Childs Drug / Alcohol Use | Unfounded | |
| | Other Child - UHM2's nephew, Male, 15 Years | Other Adult - OC1's BM, Female, 39 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - UHM2's nephew, Male, 15 Years | Other Adult - OC1's BM, Female, 39 Years | Parents Drug / Alcohol Misuse | Unfounded | |
| | Other Child - OC1's sibling, Male, 12 Years | Other Adult - OC1's BM, Female, 39 Years | Parents Drug / Alcohol Misuse | Unfounded | |
| | Other Child - UHM2's nephew's girlfriend, Female, 17 Years | Other Adult - UHM2, Female, 52 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - UHM2's nephew's girlfriend, Female, 17 Years | Other Adult - UHM2, Female, 52 Years | Parents Drug / Alcohol Misuse | Unfounded | |
| | Other Child - UHM2's nephew's girlfriend, Female, 17 Years | Other Adult - OC1's BM, Female, 39 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - UHM2's nephew's girlfriend, Female, 17 Years | Other Adult - OC1's BM, Female, 39 Years | Parents Drug / Alcohol Misuse | Unfounded | |
| | Other Child - UHM2's nephew, Male, 15 Years | Other Adult - UHM2, Female, 52 Years | Parents Drug / Alcohol Misuse | Unfounded | |
| | Other Child - OC1's sibling, Male, 12 Years | Other Adult - UHM2, Female, 52 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OC1, Female, 14 Years | Other Adult - OC1's BM, Female, 39 Years | Childs Drug / Alcohol Use | Unfounded | |
| | Other Child - OC1's sibling, Male, 12 Years | Other Adult - OC1's BM, Female, 39 Years | Childs Drug / Alcohol Use | Unfounded | |

| | | | |
|---|---|---|---|
| Other Child - OC1's sibling, Male, 12 Years | Other Adult - OC1's BM, Female, 39 Years | Inadequate Guardianship | Unfounded |

**Report Summary:**
SCR report alleged that the 55yo subject (UHM2) and her sister resided together, and were subjects concerning their children. OC1, named in the fatality report, was one of the allegedly maltreated children. The report alleged the women allowed one of UHM2's nephews and girlfriend (ages 15 and 17) to hide in their house. The women were aware UHM2's sister's children (male age 12, and OC1, age 14) and UHM2's nephew (age 15) were smoking marijuana. OC1 was suspended from school for possessing marijuana. UHM2's sister pulled a knife on OC1 in the past. UHM2 used pills and got high. The adults were allegedly not capable of caring for the CHN due to their drug use.

**Determination:** Unfounded | **Date of Determination:** 07/17/2015

**Basis for Determination:**
SCDSS interviewed OC1, her brother, their mother, and UHM2. The family denied the allegations and denied the nephew and girlfriend resided in the home.

**OCFS Review Results:**
SCDSS investigated the allegations but did not notify and interview important parties necessary for a complete investigation. SCDSS did not document efforts to locate one of the allegedly maltreated children (UHM2's nephew) or interview him. None of the biological fathers were notified or sought for interview, and the parents of UHM2's nephew and girlfriend were not notified or interviewed. The 7-day Safety Assessment was not completed on time.

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

**Issue:**
Face-to-Face Interview (Subject/Family)

**Summary:**
SCDSS did not document efforts to locate one of the allegedly maltreated children (UHM2's nephew) or interview him. None of the biological fathers were sought for interview, nor the parents of UHM2's nephew and girlfriend.

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

**Action:**
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

**Issue:**
Timely/Adequate Seven Day Assessment

**Summary:**
The 7-day Safety Assessment was 14 days late.

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

**Action:**
SCDSS will complete all safety assessments in the timeframes established by statute/law/regulation.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 03/24/2015 | Sibling, Male, 13 Years | Mother, Female, 29 Years | Educational Neglect | Indicated | Yes |

**Report Summary:**
SCR report concerned the 13-year-old SS, alleging he had attendance issues impeding his academics. He was discharged

from one school on 1/20/15 with 26 absences, and from 1/20/15 through 2/23/15 he was not enrolled at all. Between 2/23/15 and the report date, he had 12 absences.

**Determination:** Indicated | **Date of Determination:** 03/30/2015

**Basis for Determination:**
SCDSS found credible evidence to substantiate the allegations based on information from the family and school.

**OCFS Review Results:**
Though there was no investigation conclusion written, information regarding the determination was known from information in the concurrent investigation dated 1/16/15-3/27/15. OCFS' review findings were the same as in that concurrent investigation, due to the fact that the same issues were alleged and investigated.

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

**Issue:**
Timely/Adequate Case Recording/Progress Notes
**Summary:**
There was no documented investigation conclusion narrative pertaining to this investigation.
**Legal Reference:**
18 NYCRR 428.5
**Action:**
SCDSS will document relevant case information concurrent with the event dates.

**Issue:**
A child was born during an open CPS investigation and never added to the report
**Summary:**
Children who were known in recently closed cases, at least one of whom was observed, were not added to the report, nor their name, age or condition recorded.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(e)
**Action:**
Part of the full child protective investigation includes obtaining the name, age and condition of other children in the home.

**Issue:**
Failure to provide notice of report
**Summary:**
Documentation did not reflect that all biological fathers were notified of the report.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 01/16/2015 | Sibling, Female, 6 Years | Mother, Female, 29 Years | Educational Neglect | Indicated | Yes |
| | Sibling, Female, 6 Years | Mother, Female, 29 Years | Inadequate Guardianship | Indicated | |
| | Sibling, Male, 13 Years | Mother, Female, 29 Years | Educational Neglect | Indicated | |
| | Sibling, Male, 13 Years | Mother, Female, 29 Years | Inadequate Guardianship | Indicated | |

| | | | |
|---|---|---|---|
| Sibling, Male, 12 Years | Mother, Female, 29 Years | Educational Neglect | Indicated |
| Sibling, Male, 12 Years | Mother, Female, 29 Years | Inadequate Guardianship | Indicated |
| Sibling, Male, 9 Years | Mother, Female, 29 Years | Educational Neglect | Indicated |
| Sibling, Male, 9 Years | Mother, Female, 29 Years | Inadequate Guardianship | Indicated |
| Sibling, Male, 7 Years | Mother, Female, 29 Years | Educational Neglect | Indicated |
| Sibling, Male, 7 Years | Mother, Female, 29 Years | Inadequate Guardianship | Indicated |

**Report Summary:**
SCR report alleged SM moved to a new school district 2 weeks prior to the report date, but had not registered 5 SS, who had a history of absences. The children were regressing academically as a result of the absences. The mother was unwilling or unable to ensure the children's attendance. Two children were also in need of an evaluation to determine service need. A subsequent report was received on 2/11/15, again concerning the children's absences, noting they had not been to school since 12/19/15 and the mother had been made aware through multiple phone calls.

**Determination:** Indicated | **Date of Determination:** 03/27/2015

**Basis for Determination:**
SM admitted fault for the children missing an excessive amount of school following a move to a new school district. She enrolled the children in school on 2/23/15. SCDSS found credible evidence that there was negative impact and/or risk of such based on the mother's actions/inactions. The family continued to work with SCDSS in their open Services case upon the close of the investigation.

**OCFS Review Results:**
SCDSS made diligent efforts to speak to the mother and children, and see the home, despite SM's initial lack of cooperation. SCDSS gathered sufficient information upon which to determine the report. There were no efforts to interview any biological fathers and none were added to the report. There were 2 other SS known to historically reside with SM and workers documented seeing another child not listed on the report, but those children were never added to the case.

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

**Issue:**
Timely/Adequate Case Recording/Progress Notes
**Summary:**
Progress notes were not completed timely; all were written on the date the case closed.
**Legal Reference:**
18 NYCRR 428.5
**Action:**
All progress notes will be entered as contemporaneously as possible to their event dates.

**Issue:**
A child was born during an open CPS investigation and never added to the report
**Summary:**
Children who were known in recently closed cases, at least one of whom was observed, were not added to the report, nor their name, age or condition recorded.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(e)
**Action:**
Part of the full child protective investigation includes obtaining the name, age and condition of other children in the home.

**Issue:**
Failure to provide notice of report
**Summary:**

Documentation did not reflect that all biological fathers were notified of the report.

**Legal Reference:**

18 NYCRR 432.2(b)(3)(ii)(f)

**Action:**

SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report.

[redacted]

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

Between 2007 and 2014, SM was the subject of 17 CPS reports involving the SS; 8 were IND against her. Substantiated allegations ranged from IG, LS, L/M/C, B/S, and EdN; the most recurring- IG and EdN. A Neglect Petition was filed against SM in July of 2012; the SS were later temporarily removed due to SM's arrest (resulting from an incident with 10yo SS where she dragged him down the stairs and pushed him causing him to trip and almost fall). SCDSS remained involved with COS. SM was IND on 4 more CPS reports in 2013 and 2014 following their return home.

A report in 2012 was UNF against a FF for SA regarding 2 female SS (then ages 7 and 2).

OC1 was a non-confirmed maltreated CH in 2009 and 2011 against her BM for IG and IF/C/S as well as in 2012 against her PS for IG. She was a confirmed maltreated CH in 2013 against her SM for IF/C/S and IG, and again in 2014; once for EdN, EXP, and IG against her BM and uncle, and once for IF/C/S and IG against her BM.

The 55yo female subject (UHM2) had CPS history regarding her CHN and relative CHN of whom she had legal custody. In 1993 and 1994, she was IND for 3 reports, allegations including EdN, IG, and PD/AM regarding 2 of her CHN. She was IND for EdN of her 2 CHN and 2 CHN in her care in 2008 and again in 2014 for IG of her CH. Three additional UNF reports included similar allegations along with XCP on one occasion.

The 25yo and 20yo subjects had no CPS history as subjects.

3 subjects (55, 52 and 23yo) had no known CPS history.

## Known CPS History Outside of NYS

There is no known CPS history for any of the subjects or children outside of NYS.

## Preventive Services History

4/9/08-1/14/09 Mandated Services (MS) for UHM2 & her CH concerning EdN & IG; improvements by case close. 11/24/14-6/4/15 MS for UHM2 & her CH; concerns for failure to protect CH. COS were MH & substance abuse Tx, DV counseling, & parent training; some change occurred. Court orders vacated when CH turned 18. 10/27/16-10/5/18 MS for a relative CH in UHM2's custody; admitted to long term placement at the request of Probation. Case closed when CH met discharge requirements & received necessary services.

5/14/08-4/13/09 Voluntary case opened with concerns for SM's MH & care/supervision of the SS with behavior problems. Some progress made, but case later closed for non-compliance. 7/12/12 MS following Neglect Petition against SM. Ongoing concerns for SM's & SS's MH, & SS's behaviors & academic performance. Six SS were briefly removed in 2012; 1 remained in an institution where his MH needs were met. Court activity was ongoing, with additional COS. The SS were removed again in 2016 & remained in FC. Over the years, SCDSS provided & arranged for services such as supervision, casework counseling, parenting skills, child & parent MH services, family therapy, & monitoring. Some years

there was progress; other years, regression. The case remains open; the last FASP before the fatality noted housing still needed for CHN to be with SM.

## Foster Care Placement History

The SS have twice been removed from the SM's care. The SC was never removed prior to her death. The first time the SS were removed, SM was arrested for Endangering the Welfare of a Child on 11/7/12 and since there were no resources to care for the CHN at that time, CPS removed all 8 SS and placed them in Foster Care. All the children were physically returned to SM on 11/16/12, except the second eldest SS who underwent a 60-day diagnostic evaluation then ended up being placed in a residential center following the evaluation through the custody of SCDSS. He remains in placement since that time.

The second time the siblings were removed, SM failed to appear in court on 3/2/16 on Neglect proceedings, and there were ongoing concerns for SM's untreated MH, the CHN's excessive school absences, and poor condition of the home. Six of the 8 SS were removed; one SS was released to SM with a private plan in place for him to reside with his friend's family. He was later added to the order and placed on 3/24/16 when the previous plan was deemed unfit. The other SS was already in a residential treatment facility. It was determined that SS could move to a lower level of care, and was reunited to live with his siblings on 2/17/17. The CHN remained together in Foster Care at the time of the SC's death, as the only uncompleted goal of SM was to obtain housing for herself and the CHN.

## 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

| **Family Court Petition Type:** FCA Article 10 - CPS | | |
|---|---|---|
| **Date Filed:** | **Fact Finding Description:** | **Disposition Description:** |
| | There was not a fact finding | Order of Supervision |
| **Respondent:** | 045621 Mother Female 32 Year(s) | |
| **Comments:** | During an open CPS investigation between the dates of 9/10/15 and 12/4/15, SCDSS filed another Neglect Petition against SM to include allegations of EdN regarding the SS. Court proceedings had been ongoing before this was filed, and continued in the years to follow. SM failed to appear during a hearing on 3/2/16 and the Judge ordered removal of the SS. Permanency hearings to follow resulted in continuation of the SS in Foster Care with the goal continuing as return to parent. | |

| **Family Court Petition Type:** Other Family Court (Including Article 6 Custody/Guardianship | | |
|---|---|---|
| **Date Filed:** | **Fact Finding Description:** | **Disposition Description:** |
| | There was not a fact finding | CustodyGuardianship assigned to relative or non-relative (Article 6 non-foster care) |
| **Respondent:** | None | |
| **Comments:** | In 2015, UHM2 filed for and was awarded custody of 2 relative children. SCDSS was involved with the family in a CPS investigation at the time and documented UHM2 had cared for the children most of their lives, and the children's mother had left, her whereabouts unknown. | |

## 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