Child Fatality Report

Report Identification Number: SV-21-052

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

Issue Date: May 26, 2022

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 12 year(s)
Jurisdiction: Sullivan
Gender: Male
Date of Death: 12/14/2021
Initial Date OCFS Notified: 12/14/2021

Presenting Information

An SCR report alleged the 12-year-old male subject child had type 1 diabetes and required daily monitoring of his blood sugar levels. The mother failed to properly monitor and treat the child's blood sugar levels. The child was lethargic and ill for a number of days before the mother sought medical treatment for the child. When she brought the child to the hospital on 12/12/21, he had an extremely elevated blood sugar level. The child was airlifted to another hospital where he went into a diabetic coma and was placed on life-support. The child's condition did not improve and he was declared deceased on 12/14/21.

Executive Summary

This fatality report concerns the death of the 12-year-old child that occurred on 12/14/21. The child died during an open CPS investigation that began on 12/12/21. That report alleged the child was diagnosed with diabetes and was prescribed medication. The child was ill, and the mother did not adequately monitor or treat the child's high blood sugar levels. The mother was alleged to have given the child Gatorade and as a result, the child went into diabetic ketoacidosis and subsequently passed away. On 12/22/21, an SCR report was made regarding the death. At the time of the death, the child resided with his mother and 17-year-old sibling. The sibling was assessed to be safe in the care of the mother.

Sullivan County Department of Social Services (SCDSS) contacted law enforcement upon learning of the death. Law enforcement did not pursue a criminal investigation. An autopsy was not completed; however, SCDSS obtained a copy of the death certificate which noted the manner of death as natural. The cause of death was natural causes, neurocardiogenic shock, cerebral edema, and diabetic ketoacidosis. Other significant contributing conditions included morbid obesity and type 1 diabetes.

SCDSS interviewed the mother, who reported the child became ill on 12/9/21 and was vomiting. She sought medical attention on 12/10/21, and the child tested positive for a respiratory virus. The child was advised to stay hydrated and rest. The child's blood sugar was tested at home and did not reach a level the mother considered to be concerning. On 12/12/21, the child was increasingly lethargic, and the mother brought him to the hospital.

Hospital staff reported when the child arrived at the hospital, he was in severe diabetic ketoacidosis and therefore was airlifted to another hospital for a higher level of care. The child was placed on a ventilator, and he had a poor prognosis and no brain activity. The child passed away after life support was withdrawn.

SCDSS gathered information from the child's pediatrician, school staff and the endocrinologist. The record did not reflect the collateral contacts had concerns for the child's care and believed the mother did everything she could to help the child. There were no concerns for the safety of the sibling.

SCDSS conducted home visits and obtained information to complete a thorough investigation. Although diligent attempts were made to obtain locating information and contact the fathers of the children during the fatality investigation, the case record regarding the investigation open at the time of death did not include this documentation. The fathers were unable to be located or interviewed despite attempts to do so. The required reports, Safety Assessments and Risk Assessment Profile were completed with accuracy.

The allegations of Lack of Medical Care and DOA/Fatality were unsubstantiated against the mother. SCDSS documented

the investigation did not reveal credible evidence the mother's actions or inactions played a role in the child's death. The child's endocrinologist stated that in her professional opinion, the rapid decay in the child's health was a result of the child's respiratory infection that caused stress to the child's body. Additionally, the mother did everything she could to manage the child's diabetes. Furthermore, information from the school nurse and pediatrician noted the mother was compliant with the child's medical appointments and his treatment and followed up with providers when she had any questions or concerns.

SCDSS provided referrals for funeral assistance and bereavement services to the mother and sibling. It remained unknown if the funeral assistance was utilized. The family declined referrals for bereavement services. The family did not require further involvement from SCDSS and the investigations were closed timely.

PIP Requirement
SCDSS will submit a PIP to the Westchester Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the 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?** 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:
The decision to close the case was appropriate.

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 met regulatory standards.

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: 12/14/2021 **Time of Death:** 01:35 PM

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

County where fatality incident occurred: Sullivan
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **bedside**

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	Male	12 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	17 Year(s)
Other Household 1	Father	No Role	Male	51 Year(s)

LDSS Response

On 12/14/21, SCDSS learned of the child's (SC) death that occurred on the same day and began gathering information. LE, the DA and the ME's office were made aware of the death and a CPS history check was completed timely.

On 12/13/21, SCDSS spoke with hospital staff who reported the mother (SM) said the SC was nauseous and vomiting since 12/9/21. The SC's blood sugar level was higher than 600 mg/dL at the time he arrived at hospital. The SM gave the SC Gatorade to keep him hydrated, but she inadvertently gave the SC Gatorade with sugar in it. The SC had difficulty breathing and the SM attributed it to the SC's respiratory infection. The SC became increasingly drowsy, so the SM brought him to the hospital on 12/12/21. Hospital staff said the SC was likely in diabetic ketoacidosis when he arrived, and he was airlifted to another hospital for a higher level of care.

When the SC arrived at the second hospital, the SC's blood sugar level spiked above 999 mg/dL. He was sleepy, non-conversational and he was not complying with requests. The SC was put on a ventilator and had no brain activity. The SM made the decision to withdraw care.

On 12/15/21, the SM reported that while at school on 12/9/21, the SC was not feeling well, and the school's nurse called her to pick him up. The SM described the SC's breathing to be rapid and that his blood sugar levels were in a normal range at 180 mg/dL. The SM tested his blood sugar levels 3-4 times a day since he fell ill, and the SC's levels remained normal to slightly elevated considering his normal range. The SC had difficulty breathing and he slept more than normal and on 12/10/21, the SM brought the SC to urgent care. The SC was diagnosed with a respiratory infection; however, his blood sugar level was not tested during that appointment. The SC was advised to hydrate and rest. On 12/12/21, the SC was too tired to walk so the SM brought him to the hospital. According to the SM, the SC was not on a special diet but was told to monitor his carbohydrate consumption.

The sibling was interviewed on 1/3/22. He said the SC was good about managing his own diabetes. The sibling reported the SC checked his blood sugar levels 3 times a day and administered insulin. While the SC was sick, the SM and sibling watched the SC when he tested his levels, and they were not at a concerning level.

SCDSS spoke to the endocrinologist and the medical records were obtained. The endocrinologist reported the SC made progress in monitoring his diabetes, despite some increases in his blood sugar levels. She said it would be possible for the SC to have higher than normal blood sugar levels due to stress on the body due to a respiratory infection. In her professional opinion, non-compliance in managing the SC's diabetes was not the cause of his rapid decay and subsequent death. She was aware the SM gave the SC Gatorade with sugar in it; however, could not say for certain that this contributed to the SC's condition and believed the SM's priority was to keep the SC hydrated. Despite the SM denying the SC had any specific dietary plans, and the endocrinologist verbally agreeing, the medical records note the patient's plan was to eat a heathy diet, exercise and eat moderate portion meals, avoiding many carbohydrates and simple sugars while increasing protein, fruits, and vegetables.

The school's nurse reported the SC received insulin shots during the day and she never had a reason to contact the SM or the SC's providers out of concern for the SC's blood sugar levels or the level of care the SM provided to him. The cafeteria staff was unaware of any special diet plan for the SC.

After speaking with the family and collateral contacts, SCDSS did not gather sufficient evidence that the SM's actions or inactions were neglectful or that she was responsible for the SC's diabetic ketoacidosis or subsequent death.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: Sullivan County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059731 - Deceased Child, Male, 12 Yrs	059733 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
059731 - Deceased Child, Male, 12 Yrs	059733 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
059731 - Deceased Child, Male, 12 Yrs	059733 - Mother, Female, 30 Year(s)	Lack of Medical Care	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?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
Although diligent attempts were made, SCDSS was unable to make face-to-face contact with the fathers. Law enforcement did not complete a criminal investigation into the death.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐

Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The mother declined bereavement services for herself and the sibling. It remained unknown if she utilized the funeral assistance offered to her.

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 sibling did not need to be removed as a result of the fatality.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The sibling was offered mental health services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was offered bereavement services and funeral assistance.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/12/2021	Deceased Child, Male, 12 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 12 Years	Mother, Female, 30 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
An SCR report alleged the 12-year-old subject child was diagnosed with diabetes and was prescribed medications. The child was ill and vomiting since 12/9/21 and the mother failed to adequately monitor and treat the child's medical condition. The mother gave the child full sugar Gatorade. As a result, the child went into diabetic ketoacidosis with a blood sugar level of over 1000 mg/dL. The child had tachycardia (rapid heartbeat) and tachypnea (rapid breathing) and required intubation.

Report Determination: Unfounded **Date of Determination:** 02/08/2022

Basis for Determination:
The allegations of Inadequate Guardianship and Lack of Medical Care were unsubstantiated against the mother with regard to the child. The mother acted appropriately and brought the child for medical attention. The Investigation Conclusion Narrative noted the endocrinologist and hospital records did not provide "enough evidence" to substantiate the allegations.

OCFS Review Results:
The case was initiated timely and the source of the report was contacted. The record did not reflect attempts to contact the fathers of the child or sibling, or provide them with written notice of the report. A CPS history check was completed timely; however, the 7-day Safety Assessment was completed untimely. The Risk Assessment Profile was completed accurately.

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

Issue:
Failure to provide notice of report

Summary:
The record did not reflect the fathers of the children were provided with written notice of the SCR 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:

Timely/Adequate Seven Day Assessment

Summary:

With regard to the investigation that began on 12/12/21, although the 7-day Safety Assessment was completed accurately, it was completed untimely on 12/20/21.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

SCDSS will document and approve all Safety Assessments within the required timeframe.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/19/2021	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 11 Years	Other Adult - Mother's Former Partner, Male, 46 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 11 Years	Other Adult - Mother's Former Partner, Male, 46 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

An SCR report alleged the mother and her former partner sold crack-cocaine out of the home while the subject child was present. There was inadequate food in the home for the child, causing him to beg for food from neighbors.

Report Determination: Unfounded **Date of Determination:** 04/27/2021

Basis for Determination:

The allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter were unsubstantiated against the mother and the mother's former partner. Interviews with the family and the mother's former partner did not reveal drug activity or drug misuse amongst the adults. The home was observed to have ample food for the family.

OCFS Review Results:

The investigation was initiated timely, a history check was documented and progress notes were entered contemporaneously to their event dates. The mother and sibling were interviewed. The record did not reflect the mother's former partner nor the father were interviewed face-to-face. The record did not reflect ongoing monitoring of the family from 02/23/21- 04/06/21.

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

Issue:

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

Summary:

Although the father was mailed a notice of existence letter, the record did not reflect attempts to interview him. The record did not reflect attempts to interview the mother's former partner face-to-face.

Legal Reference:

18 NYCRR 432.1 (o)

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:

Failure to provide notice of report

Summary:

Although the mother, her former partner and the child's father were provided with written notice of the SCR report, the record did not reflect the sibling's father was provided with written notice.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/21/2020	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 16 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 11 Years	Other Adult - Mother's Former Partner, Male, 46 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 16 Years	Other Adult - Mother's Former Partner, Male, 46 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

An SCR report alleged the mother and her former partner sold crack and cocaine out of the home in the presence of the subject child and sibling. There was drug traffic throughout the day and night on a consistent basis. It was unknown if the drugs or drug paraphernalia were accessible to the children. The mother's former partner and the sibling engaged in a verbal dispute and the mother sided with the mother's former partner. This caused the sibling emotional distress and as a result, he ran away several times.

Report Determination: Unfounded | **Date of Determination:** 02/24/2021

Basis for Determination:

The allegation of Inadequate Guardianship was unsubstantiated against the mother. The investigation revealed the sibling resided with his godmother in Pennsylvania. The mother's former partner did not reside in the home and had not had a relationship with the mother for the last ten years. There were no police reports regarding drug activity at the apartment complex. The Investigation Conclusion Narrative did not note a basis for determination regarding the allegation against the mother's former partner.

OCFS Review Results:

The investigation was initiated timely, and a CPS history check was documented. Written notice of the SCR report was provided to the mother, her former partner and the father; however, was not provided to the father of the sibling. The record did not reflect attempts to contact or interview the fathers of the children or to interview the mother's former partner face-to-face. The safety of the sibling was adequately assessed out-of-state. The investigation was focused on the allegation of the SCR report, and did not include an overall assessment of safety and risk. The Risk Assessment Profile was completed inaccurately.

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

Issue:

Failure to provide notice of report

Summary:

Although the mother, her former partner and the father were provided with written notice, the father of the sibling was not provided with written notice of the SCR 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:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The Risk Assessment Profile was completed inaccurately as it did not reflect a child listed on the report was in the care of an alternate caregiver. The record reflected the sibling was in the care of his godmother.
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:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
With exclusion of the SS, interviews with the family were allegation-focused and did not encompass safety and risk factors that may have been present including supervision and forms of discipline. The record did not reflect the mother's former partner, who was a subject of the report, was interviewed face-to-face. The record did not reflect attempts to interview the fathers.
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 and parents of children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/12/2020	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 16 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the mother had a history of kicking the subject child and sibling out of the home. On 10/12/20, the mother kicked the children out of the home and failed to make an adequate plan for their care. The mother locked the door to the home and refused to allow the children back inside.

Report Determination: Unfounded | **Date of Determination:** 11/13/2021

Basis for Determination:
The allegation of Inadequate Guardianship was unsubstantiated against the mother regarding the children. The investigation revealed that false allegations were posted on social media that the mother kicked the children out of the house; however, the source of the information stated he was upset, and the information was untrue. Collateral contacts

were made and they denied the children were ever locked outside of the home. There was no credible evidence to support the allegation.

OCFS Review Results:
The investigation was initiated timely and the source of the report was contacted. An SCR check was documented timely. A home visit was made, and the safety of the children was assessed. Attempts were made to contact the mother's former partner and he was added as the biological father on the case; however, he is not the father of either child. The record did not reflect attempts to contact the fathers regarding the SCR report. The 7-day Safety Assessment was completed timely and accurately.

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

Issue:
Failure to provide notice of report
Summary:
Although the mother was provided with written notice, the record did not reflect the mother's former partner, or the fathers of the children were provided with written notice of the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
SCDSS will make diligent efforts to contact absent parent(s) of children and any other adult 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 face-to-face contacts with the child and/or child's parents or guardians
Summary:
The record did not reflect attempts to include the fathers of either child in the investigation.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
SCDSS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/06/2020	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 16 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 16 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the home the mother, child and sibling resided in was deplorable. There were petrified dog feces on the floor. There were bags of clothes on the floor that were leaning against a heater, creating a fire hazard. There were bed bugs in the home that were not treated since July 2019. There was garbage and fruit flies throughout the home.

Report Determination: Unfounded | **Date of Determination:** 04/02/2020

Basis for Determination:
The allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter were unsubstantiated against the mother regarding the children. Home visits were conducted and the home was not observed to be in the condition alleged in the SCR report. There were no safety concerns revealed and the children appeared well cared for.

OCFS Review Results:
The investigation was initiated timely, and a CPS history check was documented. The source of the report was contacted, and collateral contacts were made. Home visits and interviews were conducted. Written notice of the SCR report was provided to the mother, but not to the fathers or the maternal grandmother who was listed on the case. The record did not reflect attempts to include the fathers in the investigation. Services were offered to the family as the mother needed assistance with new housing, temporary assistance and food stamps. The mother did not respond to phone calls and letters regarding the preventive services case, and the investigation was closed.

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

Issue:
Failure to provide notice of report

Summary:
Although the mother was provided with written notice of the SCR report, the record did not reflect the fathers or the grandmother listed on the report were provided with written notice.

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 face-to-face contacts with the child and/or child's parents or guardians

Summary:
The record did not reflect attempts to include the fathers of either child in the investigation.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
SCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/31/2019	Deceased Child, Male, 9 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 9 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 14 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 14 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Cousin, Male, 10 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

Other Child - Cousin, Male, 10 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 9 Years	Aunt/Uncle, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 9 Years	Aunt/Uncle, Female, 35 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 14 Years	Aunt/Uncle, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 14 Years	Aunt/Uncle, Female, 35 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Cousin, Male, 10 Years	Aunt/Uncle, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - Cousin, Male, 10 Years	Aunt/Uncle, Female, 35 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 9 Years	Aunt/Uncle, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 9 Years	Aunt/Uncle, Male, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 14 Years	Aunt/Uncle, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 14 Years	Aunt/Uncle, Male, 30 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Cousin, Male, 10 Years	Aunt/Uncle, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - Cousin, Male, 10 Years	Aunt/Uncle, Male, 30 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report alleged the mother was addicted to opioids and was hospitalized. The mother was discharged but continued to use drugs. There was no food in the home, and the child, sibling and cousin begged for food from the neighbors. The cousin was not attending school and there were people coming in and out of the home on a regular basis.

Report Determination: Unfounded | **Date of Determination:** 11/15/2019

Basis for Determination:
The allegations of IG and IF/C/S were unsubstantiated against the mother, uncle and aunt regarding the subject child, sibling and cousin. The basis for determination stated there was limited food in the household and the grandmother resided across the street and provided a safe environment for the children. The Investigation Conclusion Narrative did not address the allegations of the mother misusing drugs or include a basis for determination regarding allegations against the aunt and uncle.

OCFS Review Results:
The investigation was not initiated timely and the 7-day Safety Assessment was completed untimely. Written notice was not provided to all adults. The record did not reflect attempts to contact the biological fathers. There was no documentation the child, sibling, aunt and uncle were interviewed. Allegations of the mother's drug use was not adequately assessed. The Risk Assessment Profile was completed inaccurately. The case was closed without documentation of a full investigation including a full assessment of the risk and safety of the children.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-day Safety Assessment was completed without gathering information to address the overall safety of the children. The record did not reflect family members or collateral contacts were made until 6/11/19. The 7-day Safety Assessment was completed untimely on 6/18/19, 11 days late.

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

Action:
Within seven days of receiving a report, SCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Issue:
Failure to provide notice of report

Summary:
Although the mother, aunt and uncle were provided with written notice, the fathers of the subject child and sibling were not provided with written notice of the SCR 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:
Timely Commencement of Investigation

Summary:
The case was not initiated timely as the record did not note how the safety of the children was assessed or attempted to be assessed between the date of the report, 5/31/19, and the first attempted contact with the family on 6/11/19.

Legal Reference:
SSL 424(6);18 NYCRR 432.2(b)(3)(i)

Action:
Within 24 hours of receiving a child abuse and/or maltreatment report, SCDSS must conduct a face-to-face contact or a telephone contact with the subjects and/or other persons named in the report or other persons in a position to provide information about whether the child may be in immediate danger of serious harm.

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

Summary:
Although the SM was spoken to on 6/11/19 and the CHN were observed, they were not interviewed. The record did not reflect anyone was interviewed regarding the SM’s alleged drug misuse. The record did not reflect the MA, MU, SS or SC were interviewed regarding the allegations of the report or overall safety and risk. The record did not note attempts to contact the fathers of the SS or SC.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
SCDSS will incorporate key safety-related questions as they pertain to case circumstances. The child(ren) and every other child in the household should be interviewed prior to closing the investigation. The alleged subjects of the report as well as the parents must be interviewed as part of the investigation.

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:

The Risk Assessment Profile was completed inaccurately as it did not reflect that the cousin was residing with his grandmother due to the aunt's drug misuse and the illegal behaviors of her roommates.

Legal Reference:

18 NYCRR 432.2(d)

Action:

SCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The record did not reflect casework activity took place from 6/11/19 through 8/7/19 and the record did not reflect safety or risk assessments of the CHN. The SC and SS were not interviewed. The aunt resided with drug users and used illegal drugs; however, the investigation did not note the concerns were addressed further. The case was closed without fully assessing the safety of the CHN.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

SCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

[redacted]

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

7/29/17- 10/20/17 Allegations of Inadequate Guardianship and Parent Drug/Alcohol Misuse against the mother and three other adults were unsubstantiated regarding the subject child, the sibling and another child.

6/6/17- 8/25/17 Allegations of Inadequate Guardianship, Lack of Supervision, and Parent Drug/Alcohol misuse against the mother and three other adults were unsubstantiated regarding the subject child, the sibling and another child.

5/9/14- 7/15/14 The mother's former partner was unsubstantiated for the allegation of Inadequate Guardianship of the children.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No