Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-18-033

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

Issue Date: Jan 18, 2019

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: 6 year(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 07/20/2018
Initial Date OCFS Notified: 07/22/2018

Presenting Information

An SCR report received on 07/20/2018 alleged the SM failed to seek medical attention and provide the 6-year-old SC with required medication for his ongoing medical condition. The SM failed to provide the SC with medication for the past year. The SM continuously missed medical appointments for the SC. On 7/18/18, at approximately 8:00PM, the SM fed the SC through his feeding tube. At approximately 8:20PM, she found the SC unresponsive and not breathing, called 911 and began CPR until EMS arrived. EMS responded to the home and transported the SC to the hospital, where the SC was admitted to the pediatric intensive care unit. On 7/20/18, at 12:53PM, the SC was pronounced brain-dead and at 6:46PM, the SC was taken off life support and pronounced dead. The SC's death was a direct result of the SM's failure to ensure the SC was treated for his medical condition. The MGF was not home on 7/18/18, at 8:00PM, and had an unknown role.

Executive Summary

Onondaga County Department of Social Services (OCDSS) received the report of the death from the SCR on 07/20/18. There was an open investigation received two days prior, concerning the incident that lead to the SC's death, and repeated concerns of medical neglect by the mother (SM).

The SC had significant medical concerns, including a congenital heart disease, which affected his lungs, and a developmental delay. The SC had poor mobility, was nonverbal and required a feeding port. The SC required treatment from multiple medical specialists. He was prescribed medication for his heart, but they had not been provided for over a year because it was not covered by insurance and the mother could not afford it. Although this concern was brought to the attention of OCDSS in 2017, the family's case was closed on 05/08/18, without rectification.

OCDSS and LE conducted a joint investigation into the death. During the investigation, it was learned the mother noticed the child was not breathing on 07/18/18. She called 911 and the SC was transported to the hospital. The child was revived, but later died when life support was removed.

An autopsy was performed and the report determined the SC's cause of death was "pulmonary hypertension due to cardiac malformation due to multiple congenital anomalies" and the manner of death was natural.

OCDSS contacted the father regarding the death; however, he was not offered any services in response to the fatality.

Although there was information known to OCDSS the maternal grandfather (MGF) lived in the home and was a regular caretaker of the child, no allegations were reported against him or added regarding his ongoing neglect of the SC.

Through a review of CPS history, it was learned the child had significant medical issues throughout his life, which had been brought to the attention of OCDSS on multiple occasions prior to the fatality. The SCR reports contained repeated allegations of lack of medical care, and were closed by OCDSS without the concerns being fully explored, nor were the concerns rectified prior to case closing. A review of the family's history revealed OCDSS did not conduct thorough investigations and/or follow regulatory standards. The investigations lacked collateral contacts with all medical providers and did not document the family's service needs were being met. During the history, there were multiple occasions when timely and appropriate intervention could have assisted the family's functioning, and were identified by OCDSS; however, no rectifiable action was taken and the cases were closed. The record did not reflect a Preventive Case was

opened for the family to provide ongoing monitoring of all necessary medical treatment recommendations, physical and speech therapies, or to verify the child's needs were being met. Additionally, no court action was sought to protect the child.

LE arrested the SM on one count of Endangering the Welfare of a Child. She was sentenced to 3 years of probation, which will include alcohol abuse treatment and parenting classes.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The interview with the MGF was not documented to include any concerns he had for the child prior to the death.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:
The case remained open for investigation.

Required Actions Related to the Fatality

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

Issue:	Face-to-Face Interview (Subject/Family)
Summary:	Although spoken with, interviews with the SM and MGF did not include family functioning, risk, and safety. There was not documentation the BF was asked about any concerns he may have had.
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:	Contact/Information From Reporting/Collateral Source

Summary:	OCDSS missed opportunities to obtain additional information as they did not contact first responders or the mother's partner, who was present immediately after the fatal incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	OCDSS will make diligent efforts to contact relevant collateral sources and all biological parents of the child(ren) listed in the household composition.
Issue:	Failure to offer services
Summary:	SM and MGF were offered bereavement services. However, the mother had an identified need for assistance with health insurance and mental health services, but these were not offered. There was no documentation of any services offered to the BF.
Legal Reference:	SSL §424(10);18 NYCRR 432.3(p)
Action:	When service needs are identified, OCDSS will make the appropriate referral to Preventive Services in an effort to determine whether there are services that can benefit the family.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/20/2018 **Time of Death:** 06:46 PM

Date of fatal incident, if different than date of death: 07/18/2018
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 08:10 PM
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
How long before incident was the child last seen by caretaker? 20 Minutes
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	Male	6 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	63 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Other Household 1	Father	No Role	Male	28 Year(s)

LDSS Response

OCDSS initiated their investigation within 24 hours of receipt of the report. They spoke to the source, reviewed CPS history, notified the DA and ME, and requested medical records.

Interviews were conducted by both OCDSS and LE, and LE shared their records. The SC had sounded significantly congested, developed cold-like symptoms and had shallow breathing for 3 days prior to the fatal incident. The SM increased the amount of oxygen the SC was being administered, but did not seek medical attention.

On the night of the fatal incident, the SM and SC were in the living room when the SM heard him cough; then noticed he was not breathing. She attempted to wake him, then called 911 and began CPR until first responders took over. The SC was taken to the hospital, where he died after life support was removed on 07/20/18.

At the hospital, the SC presented with friction alopecia and a rash from not moving around often. The SM did not change the SC's feeding bag as recommended, nor was she providing him with medication for approximately one year, as she could not afford it and did not seek any alternate medical treatment for the child.

According to EMS records obtained by LE, the home was in deplorable conditions and the SC's medical equipment was not functioning properly as a result. The oxygen tank's air filters were heavily clogged with dog fur and debris. Due to the condition of the home, the SC was unable to move around and his mobility declined. OCDSS had knowledge the SC had not seen specialists to improve his mobility since January 2018.

Although the MGF lived in the home, he was not present at the time the fatal incident took place. OCDSS had knowledge he was a regular caretaker of the SC and had reached out for assistance regarding the SC in the past. Investigation revealed the MGF knew the severity of the SC's medical conditions, and was aware of the condition of his home, yet he did not intervene to protect the child and allegations had not been added against him at the time this report was written.

OCDSS referred the SM and MGF to bereavement services, and the SM was seeking parenting classes and an alcohol abuse program, after admitting she was abusing alcohol as a coping mechanism for her ongoing and untreated MH concerns; however, there was not documentation regarding conversations as to if alcohol impacted the care the SM provided for her son.

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: 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? Yes
Comments: The fatality was reviewed by an OCFS-approved Onondaga County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047090 - Deceased Child, Male, 6 Yrs	047093 - Mother, Female, 26 Year(s)	DOA / Fatality	Pending
047090 - Deceased Child, Male, 6 Yrs	047093 - Mother, Female, 26 Year(s)	Lack of Medical Care	Pending
047090 - Deceased Child, Male, 6 Yrs	047093 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
School	☐	☒	☐	☐
Other	☐	☒	☐	☐
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:
There were missed opportunities to obtain information as the mother's boyfriend, who was present the day of the fatal incident was not contacted or attempted to be contacted. Additionally, the MGF and BF were not asked if they had prior concerns.

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
09/27/2018	The mother	Unknown	Plea deal with 3 years of Probation
Comments:	The mother was arrested for Endangering the Welfare of a child, a crime for which she accepted a plea deal. She was sentenced to 3 years of Probation, which will include alcohol abuse treatment and parenting classes.		

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:
There was not documentation the mother was offered mental health counseling, or assistance in obtaining health insurance.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM, MGF and MA were offered bereavement services. SM was ordered to engage in parenting classes and alcohol abuse treatment. There was no documentation the father was offered services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
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)
07/18/2018	Deceased Child, Male, 6 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 6 Years	Mother, Female, 26 Years	Lack of Medical Care	Substantiated	

Report Summary:
An SCR report alleged the SC was diagnosed with multiple medical conditions and required frequent evaluations by specialists. The SM had a Hx of not taking the SC to medical appointments. On 7/18/18, at 8:20PM, the SC became unresponsive, without a pulse, while in the SM's care. The SC suffered cardiac arrest and was in critical condition. The SM's failure to ensure the SC was seen by specialists contributed to the medical crisis. The SM initially refused to accompany the SC to the hospital or make herself available, impacting the Tx for the SC. The SM failed to care for the SC and he had rashes on his body and an open sore, consistent with not being moved. The role of the MGF was unknown.

Report Determination: Indicated | **Date of Determination:** 08/01/2018

Basis for Determination:
The SM had a history of failing to obtain medical treatment for the SC dating back to 2016. The SM was aware the SC required special care, and if he did not receive appropriate care, the lack of treatment could cause his death. The SM continued to neglect the SC's medical needs.

OCFS Review Results:
OCDSS immediately initiated the investigation by making a home visit and contacting LE. There were no attempts documented to speak with the maternal grandfather or father. Documentation does not show attempts were made to contact the mother's boyfriend, who was present immediately following the fatal incident. No attempts were made to contact first responders. There was not documentation that services were offered to the family in this investigation.

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

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
Although the MGF resides in the home, was a caregiver for the SC, and was listed on the SCR report, OCDSS did not interview him.
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:
Contact/Information From Reporting/Collateral Source
Summary:
There was no documentation of contact or attempts to contact the father, first responders or the mother's partner, who was present immediately after the fatal incident.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
OCDSS will contact or make diligent efforts to contact relevant collateral sources who may have information relevant to the investigation, including absent parents.

Issue:
Pre-Determination/Supervisor Review
Summary:
There was no documentation that a supervisor reviewed the investigation at the close of the case.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
Action:
OCDSS will consult supervision when determining a case and at other pertinent times throughout the investigation.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

Although the RAP was completed, some questions were answered without documenting how the information was obtained. The RAP did not include the MGF, despite having previous knowledge he was a caregiver to the child. The RAP stated the SM was an alcoholic; however, the RAP did not document how the alcohol abuse negatively affected childcare.

Legal Reference:

18 NYCRR 432.2(d)

Action:

OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile. OCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Issue:

Confidentiality of CPS Information

Summary:

Confidential information, including CPS involvement was given to the maternal aunt, and she was not a household member, caregiver or subject of the report. The case record stated that the caseworkers identified themselves and explained their reasoning for making a home visit.

Legal Reference:

SSL 422(4) and (5)

Action:

Information regarding CPS involvement and/or investigations will remain confidential unless a Release of Information has been obtained.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/20/2017	Deceased Child, Male, 5 Years	Mother, Female, 25 Years	Lack of Medical Care	Far-Closed	Yes

Report Summary:

An SCR report received on 09/20/17 alleged that the 5yo child was severely physically and developmentally disabled and had several medical issues. The child was receiving in home physical, occupational and speech therapies several times a week. The services stopped on 08/31/17, and the mother failed to obtain further treatment for the child. As a result, the child regressed in his communication and in his ability to walk. The role of the maternal grandfather was unknown.

OCFS Review Results:

The FAR case did not include documentation the family was interviewed regarding safety and risk concerns together. Progress notes were entered months after their event dates. The Safety Assessment was inaccurate, the FLAG was not completed with the family and was inaccurate. An SCR report was never made, despite 5 conversations with the SM due to her noncompliance. There was no legal consultation, despite continued neglect of the SC, and the case was closed without family agreement. Notices of Existence were not provided timely. During the FAR case, the SM was not compliant with OCDSS and the case was closed without rectifying the reported concerns.

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

Issue:

FAR-Timely/Adequate 7-Day Assessment

Summary:

A 7-day safety assessment was not completed. A safety assessment was completed 8 months after the receipt of the report and was incorrect. The safety assessment did not accurately reflect information in the case record, including the child being medically fragile.

Legal Reference:

18 NYCRR 432.13 (d)(2)(i) and (ii); 18 NYCRR 432.13(d)(3)

Action:

Whenever a report alleging maltreatment of a child is initially assigned to the family assessment response track during the 7 days following receipt of the report, the child protective service must enter the initial safety assessment into CONNECTIONS no later than 7 days after receipt of the report. Safety assessments will accurately reflect what is in the case record.

Issue:

FAR-Timely/Adequate Family-Led Assessment Guide

Summary:

The Family Led Assessment Guide (FLAG) was not completed until approximately 8 months after being tracked Family Assessment Response. Although the FLAG was completed, there was not documentation that it was completed together with the family.

Legal Reference:

18 NYCRR 432.13 (e)(2)(iii)-(v)

Action:

The Family Led Assessment Guide should be initiated as soon as possible after receipt of the child protective service report, but no more than 30 days following receipt of the report.

Issue:

FAR-Failure to Provide Notice of Report

Summary:

The SM identified the father of the child, but OCDSS did not send him the required notification of the report regarding his child until 3 months after the receipt of the report. The were not attempts to contact the father to verbally notify him of the report. The MGF was not provided written notification of the report.

Legal Reference:

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

Action:

No later than 7 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. OCDSS will make contact or attempt to make contact to verbally inform said persons.

Issue:

FAR-Inappropriate Determination of CPS/FAR Track

Summary:

Although safety/risk concerns were identified during the FAR case and multiple discussions were documented regarding making an SCR report and the mother was not cooperative with OCDSS, OCDSS did not make a new SCR report and continued to utilize the FAR track.

Legal Reference:

18 NYCRR 432.13 (c); 18 NYCRR 432.13(e)(2)(ii)(a-d)

Action:

If while conducting a FAR, the Department has reasonable cause to suspect child abuse, or the family is not cooperating with the FAR and there is reasonable cause to suspect maltreatment of a child, the case is no longer eligible for inclusion

in the FAR track and OCDSS must make a new SCR report, which follows the investigative track, and the FAR track must be closed.

Issue:
FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible
Summary:
OCDSS did not interview or attempt to interview the BF or speak with him about the report. The MGF was not interviewed regarding the concerns, despite him reaching out for assistance for the SM and the SC. OCDSS did not engage him in providing care for the child.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)
Action:
Family Assessment Response workers must work in partnership with the families participating in a Family Assessment Response. Workers should be transparent with families regarding all actions that they take regarding the case. To the extent feasible, child protective service workers should include all family members in discussions, including children who are able to express opinions.

Issue:
FAR-Improper Case Closure
Summary:
The Family Assessment Response worker did not contact or attempt to contact the family at least once every 2 weeks during the period past 90 days after the receipt of the report. The family was not seen or attempted to be seen from 10/19/17-12/7/17. The family was seen 6 times during the 8 months the report was open. Diligent attempts to engage the family were not made throughout the response.
Legal Reference:
18 NYCRR 432.13 (e)(3)
Action:
The Family Assessment Response worker must make contact with the family no less than once every two weeks during the period past 90 days and must document each contact.

Issue:
FAR-Overall Completeness/Adequacy of Family Assessment Response
Summary:
The SM's parents, who made contact with the worker, were not engaged in any assessment of the concerns reported to the SCR. The were no attempts to engage the BF in the FAR case. OCDSS did not adequately partner with the family to assist in obtaining services that would help the family meet identified needs.
Legal Reference:
18 NYCRR 432.13 (a)(1-4)
Action:
OCDSS will provide an ongoing assessment of safety and risk regarding the family. OCDSS will contact relevant, identified collaterals to assess any of the concerns reported to the SCR as well as any concerns for safety and risk. OCDSS will make or attempt to involve all biological parents and household members during the FAR case. OCDSS will offer services for identified needs of the family.

Issue:
FAR-Failure to Address Reported or Identified Concerns
Summary:
During the FAR track, it was learned the child was not engaged with service providers or medical specialists and he was not attending school. The concerns were not fully explored or addressed prior to case closure.
Legal Reference:

18 NYCRR 432.13 (a)(3)(iii)

Action:

OCDSS must engaged the family in an assessment of the concerns reported to the SCR. and family-identified needs and concerns that may impact the safety or risk of children, and the family's strengths and resources that could be engaged to address the identified concerns.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/07/2016	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:

An SCR report received on 04/07/16 alleged that the child was diagnosed with medical conditions. The child was hospitalized and almost died due to his disease. The mother had a history of missing the child's medical appointments and missed an appointment on 03/24/16. The mother's actions placed the child at imminent risk.

Report Determination: Unfounded | **Date of Determination:** 01/19/2017

Basis for Determination:

OCDSS unfounded the report as no credible evidence was revealed during the investigation to support the allegations made. OCDSS contacted medical providers and found no concerns that the child was missing medical appointments, despite his ongoing medical conditions.

OCFS Review Results:

OCDSS did not interview or notify all household members regarding the report, including the MGM, MGF or the MU. There were missed opportunities to obtain information about the child's medical condition and the care the SM provided. OCDSS did not document an assessment of possible safety and risk concerns with the mother or the child, and the investigation was allegation driven. Notice of Existence letters were provided 8 months after the due date. The Safety Assessment was inaccurate and did not reflect information in the case record. There was no documentation of supervisory review regarding case determination and closing.

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

Issue:

Failure to provide notice of report

Summary:

OCDSS did not provide the SM or the BF Notice of Existence letters until approximately 9 months into the investigation.

Legal Reference:

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

Action:

OCDSS 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. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

A 7-day Safety Assessment was not completed until approximately 9 months after the due date. The Safety Assessment did not reflect the documentation in the case record, including that the child was medically fragile.

Legal Reference:

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

Action:

OCDSS will complete all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.

Issue:

Pre-Determination/Supervisor Review

Summary:

There was no documentation that a supervisor reviewed the investigation at the close of the case.

Legal Reference:

18 NYCRR 432.2(b)(3)(v)

Action:

OCDSS will consult supervision when determining a case and at other pertinent times throughout the investigation.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

There were missed opportunities to gather collateral information, such as interviewing the household members including the maternal grandparents and maternal uncle regarding the care and safety of the child. The record did not reflect the medical specialists were contacted, and the SC's hospital records were not requested which may have provided pertinent information.

Legal Reference:

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

Action:

OCDSS 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:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

Documentation does not show efforts made to interview all household members or persons with regular contact with the mother and child. There was no documentation of the child being interviewed, or an explanation for him not being interviewed.

Legal Reference:

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

Action:

OCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the investigation.

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

There was no CPS history more than 3 years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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