Child Fatality Report

Report Identification Number: AL-18-030

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

Issue Date: May 09, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 17 year(s)
Jurisdiction: Albany
Gender: Male
Date of Death: 11/04/2018
Initial Date OCFS Notified: 11/26/2018

Presenting Information

Albany County Department of Children, Youth and Families (ACDCYF) submitted a 7065 Agency Reporting Form to the Albany Regional Office on 11/20/18 stating the child was found deceased in his bedroom from an apparent heroin overdose. The child's death occurred during an open CPS investigation.

Executive Summary

This fatality report concerns the death of the 17-year-old male subject child who was declared deceased on 11/4/18. The child died during an open CPS investigation that was received by Albany County Department of Children, Youth and Families (ACDCYF) on 10/12/18. The report included concerns the parents failed to seek immediate medical attention for the child, after he expressed suicidal ideation. The mother found the child in distress after he ingested antifreeze and called 911. The report also included concerns the child had a sexual relationship with an unrelated adult and alleged the parents failed to intervene, and the child was abusing unknown drugs.

ACDCYF learned of the death on 11/19/18, after receiving the information from the child's mother. The child died because of a drug overdose. A 7065 Agency Reporting Form was completed and sent to OCFS on 11/20/18, and ACDCYF began their investigation into the death.

Law enforcement was contacted to coordinate investigative efforts; however, law enforcement did not note any criminality. Law enforcement provided their records to ACDCYF regarding the unattended death.

The mother provided information that the child was found unresponsive on his bed on 11/4/18, she notified the adult sibling, and called 911. The child was deceased and neither the family or EMS attempted resuscitation. The coroner pronounced the child deceased at the scene, and his body was transported to Albany Medical Center. The cause of death was "Combined Toxicity" and the manner of death was accidental.

At the time of his death, the child resided with his parents. There were no minor surviving siblings, and no other children resided in the home.

During the investigation, ACDCYF completed a CPS history check, and obtained information from law enforcement, the source of the report open at the time of death, first responders, family members and school staff. The mother was offered grief counseling and mental health counseling referrals; however, she declined as she was already receiving therapy through a private counselor.

The allegations in the report were unsubstantiated. ACDCYF documented the parent's refusal to sign releases of information to gather further information regarding the alleged medical neglect of the child. The basis for determination regarding alleged medical neglect was unsubstantiated due to lack of credible evidence. Although the unrelated adult said she had a sexual relationship with the child, it was not until he was the legal age of consent; the allegation of sexual abuse was unsubstantiated against her.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The casework was commensurate with case circumstances.

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: 11/04/2018 **Time of Death:** 02:45 PM

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

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

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

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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	No Role	Male	17 Year(s)
Deceased Child's Household	Father	No Role	Male	41 Year(s)
Deceased Child's Household	Mother	No Role	Female	43 Year(s)

LDSS Response

On 11/19/18, ACDCYF received a voicemail from the child's mother stating the child had died. An ACDCYF Supervisor was made aware that the child passed away on 11/4/18, and ACDCYF notified Albany Regional Office by completing a 7065 Agency Reporting Form. The CPS investigation that was open at the time of the child's death included concerns of the child's mental health treatment and drug use. Additionally, there were concerns the child was being sexually abused by his friend's mother (OA).

After learning of the death, law enforcement was promptly contacted and information regarding the death was exchanged. Law enforcement said the child's adult brother called 911, yelled "my brother is dead" and hung up the phone. First responders arrived and found the child's body, which had begun decomposing. The child was suspected to have died of a drug overdose, and heroin was located in his bedroom. Law enforcement observed no signs of abuse or self-inflicted harm.

The autopsy was obtained and the pathologist was interviewed by ACDCYF. The pathologist noted "post mortem decomposition indicates that the body had been dead for some time before discovery." The pathologist estimated the child was deceased for two days prior to being found. The autopsy revealed the child had an abundance of street and pharmaceutical drugs in his system, including heroin, fentanyl, acetylfentanyl, tramadol and alprazolam. He noted the manner of death to be accidental; however, stated that the death could have been a result of suicide.

Investigation revealed the child intentionally ingested antifreeze in the weeks prior to his death and received medical attention at Albany Medical Center and Capital District Psychiatric Center. Information was gathered that the child cried and expressed suicidal ideation. The child was awaiting a follow-up appointment for mental health counseling; however, this could not be confirmed as the parents refused to sign a release.

ACDCYF interviewed the mother over the phone on 12/4/18. She provided a timeline of events leading up to the child's death. The mother explained she was out of town, the father was home with the child, and the adult sibling was checking in on him. She stated on 11/4/18, around 9:30AM, the father observed the child in his room, and assumed he was asleep. According to the mother, she came home around 1:30PM to find the child deceased on his bed. The caseworker advised the mother of the findings of the autopsy; however, she was adamant the father saw the child alive the night prior to 11/4/18. The mother did not believe the child used drugs prior to his death, and there was no information as to where the drugs came from.

The adult brother was spoken to on 1/4/19 regarding the death. He said on the day of his brother's death, the mother called and said there was something wrong with the child. The brother rushed to the home to find his brother face-down in bed. He reported his brother was dead at that time and he called 911. He reported last seeing his brother alive on 11/1/18 and described his brother as acting normally. He added that his brother never showed signs of depression or drug abuse.

After making multiple attempts to speak with the other adult, ACDCYF interviewed her over the phone on 12/4/18. She stated she had a sexual relationship with the child after he was the legal age of consent. She denied knowing the child was using drugs at any time. She was unable to provide any additional information regarding his death.

During the investigation, the father was not cooperative with ACDCYF and did not speak of the child's death. The mother was offered grief and bereavement counseling; however, she was already engaged in private counseling.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Pathologist

Multidisciplinary Investigation/Review

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

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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? 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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACDCYF was not made aware of the death until after the funeral services. Mental health and bereavement counseling were offered to the mother; however, the case did not reflect those services were offered to the father, adult sibling or other adult. The father and other adult were not cooperative with the investigation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was provided information regarding grief counseling and bereavement services. The record did not show the father or adult sibling was offered any services as a result of the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/12/2018	Deceased Child, Male, 17 Years	Other Adult - SC's Partner, Female, 47 Years	Childs Drug / Alcohol Use	Unsubstantiated	No
	Deceased Child, Male, 17 Years	Other Adult - SC's Partner, Female, 47 Years	Sexual Abuse	Unsubstantiated	
	Deceased Child, Male, 17 Years	Mother, Female, 43 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Male, 17 Years	Father, Male, 41 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Male, 17 Years	Mother, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 17 Years	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 17 Years	Other Adult - SC's Partner, Female, 47 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the child was admitted for suicidal ideation and he consumed antifreeze. The BM found him pale with blue lips and he was complaining of pain and went unconscious. The mother called LE, who brought him to the hospital. He made suicidal statements and threats, and threatened self-harm. The parents were aware of the child's mental state prior to him consuming antifreeze, but delayed in seeking medical attention for the child. The child was alleged to have had a sexual relationship with an adult (OA), with whom he lived for 6 months. The parents were aware and tried to have the child return home, but he refused. The adult (OA) provided drugs and alcohol to the child.

Report Determination: Unfounded **Date of Determination:** 01/29/2019

Basis for Determination:
ACDCYF unsubstantiated the allegations stating the other adult did not have a sexual relationship with the child until he was the legal age of consent. The parents were attempting to seek medical and mental health treatment for the child, but his appointment date had not yet come. ACDCYF documented the mother was unaware of the child's drug abuse, and the other adult denied providing the child drugs or encouraging him to consume antifreeze.

OCFS Review Results:
ACDCYF initiated the investigation timely and contacted collaterals. The 7-day Safety Assessment was completed timely and accurately.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

05/16/2018	Deceased Child, Male, 16 Years	Other Adult - Unrelated adult, Female, 44 Years	Childs Drug / Alcohol Use	Unsubstantiated	Yes
	Deceased Child, Male, 16 Years	Other Adult - Unrelated adult, Female, 44 Years	Educational Neglect	Unsubstantiated	
	Deceased Child, Male, 16 Years	Other Adult - Unrelated adult, Female, 44 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 16 Years	Other Adult - Unrelated adult, Female, 44 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Male, 16 Years	Other Adult - Unrelated adult, Female, 44 Years	Sexual Abuse	Substantiated	
	Deceased Child, Male, 16 Years	Mother, Female, 43 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 16 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report alleged the other adult (OA) was in a sexual relationship with the child since he was 14 years old. He stayed with the OA in motel rooms for at least one month. The OA supplied and did drugs with the child. The OA had a history of being arrested for drugs and the delinquency of minor, SC. The SC had 5-6 seizures and it was unknown if he was taking medication. The child was kicked out of school when he was 15 and was enrolled in an online academic program which he was not compliant with and was not receiving any academic instruction. The parents made police reports regarding the concerns, but the police were unable to make the SC return to his parents due to lack of evidence.

Report Determination: Indicated | **Date of Determination:** 08/14/2018

Basis for Determination:
ACDCYF was unable to interview the other adult or the child, as their whereabouts were unknown. Without input from those parties, there was enough credible evidence to substantiate the allegations as the other adult and child had a sexual relationship, according to the mother. Additionally, the parents were indicated as the investigation revealed some credible evidence to support the allegations.

OCFS Review Results:
ACDCYF contacted the source of the report and LE. The record does not reflect if the father or child were interviewed. The mother's interview did not include information regarding the child's overall risk and safety. Relevant collateral contacts were not made including the child's doctor, school, or the child's friend, who was the OA's son. The investigation did not include an assessment of the home and the record did not reflect reasonable attempts to obtain locating information for the OA. There was no documentation of a legal consultation, despite the family not knowing and/or not providing information regarding the child's whereabouts or access to the child.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP did not include the family's history of domestic violence or police involvement and did not reflect the child was in the care of a substitute caregiver.

Legal Reference:
18 NYCRR 432.2(d)

Action:
ACDCYF will accurately assess and document each respective risk element identified into the Risk Assessment Profile. ACDCYF will consider all risk elements identified throughout the course of the investigation or previous investigations and accurately document such elements into the Risk Assessment Profile.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

The record did not reflect attempts were made to contact medical collaterals who may have had information regarding the child's alleged medical condition and treatment recommendations. There were no attempts to contact any educational provider regarding the child.

Legal Reference:

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

Action:

ACDCYF will contact or make efforts to contact relevant collateral sources who may have information relevant to the investigation.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The record did not contain adequate information upon which to base a safety or risk assessment.

Legal Reference:

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

Action:

ACDCYF 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 length of the investigation.

Issue:

Pre-Determination/Home Visit

Summary:

The case record showed a home visit was attempted, but not completed. No further attempts to evaluate the environment of the child were documented.

Legal Reference:

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

Action:

Prior to a determination being made, the investigation must include one home visit so as to evaluate the environment of the child named in the report as well as other children in the same home.

Issue:

Face-to-Face Interview (Subject/Family)

Summary:

Although some attempts were made, the record did not reflect the parents or child were seen or interviewed during the investigation. The record did not show reasonable attempts to locate and interview the other adult regarding the report.

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:

Assessment as to need for Family Court Action

Summary:

Although the caseworker asked the mother about a PINS petition, there was no documentation of a follow-up. During the investigation, the mother refused to provide the child's whereabouts or contact information and there was no

documentation regarding a discussion with the ACDCYF's legal department regarding obtaining an Access Order to see the child to assess his safety.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:

The Child Protective Service worker shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/19/2016	Deceased Child, Male, 15 Years	Mother, Female, 41 Years	Educational Neglect	Substantiated	Yes
	Deceased Child, Male, 15 Years	Mother, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 15 Years	Father, Male, 39 Years	Educational Neglect	Substantiated	
	Deceased Child, Male, 15 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

An SCR report alleged the child missed 152 days of the 2015-2016 school year and failed as a result. The parents were aware of his absences, but failed to address his attendance. The mother enrolled the child in online classes, but the classes were never approved by the Board of Education. The child did not log into his program for over 90 days and was not receiving educational services. In the 2016-2017 school year, he was enrolled locally, but did not attend. He was behind academically as a result.

Report Determination: Indicated

Date of Determination: 10/28/2016

Basis for Determination:

It was determined the child missed 152 days of the 2015-2016 school year and failed the 9th grade as a result. The child was not enrolled in an educational program for the 2016-2017 school year that was approved by the local school district. Given his lack of attendance, the child was not able to advance to the next grade level for the second consecutive year.

OCFS Review Results:

ACDCYF contacted the source of the report and initiated the investigation within the required timeframe. ACDCYF did not document an assessment of the child's safety, assess the safety of the home, or make reasonable attempts to speak with the father. The record did not reflect attempts to make collateral contacts to people who may have been able to provide information regarding the child's safety and family functioning.

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

Although attempts were made to assess the safety of the child within the required timeframe, the 7-day Safety Assessment was not approved until 4 days after the due date.

Legal Reference:

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

Action:

ACDCYF will complete all Safety Assessments within the required timeframe.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
Reasonable efforts to interview the father about the report were not documented. The father was a home member, and was a subject of the report. The interview with the mother did not include an overall assessment of the child's safety and risk.
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:
Pre-Determination/Home Visit
Summary:
Although two unannounced home visits were made, the child's environment was not assessed. The record did not reflect further attempts to assess the safety of the home.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(a)
Action:
Prior to a determination being made, the investigation must include one home visit so as to evaluate the environment of the child named in the report as well as other children in the same home.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/03/2015	Deceased Child, Male, 14 Years	Mother, Female, 42 Years	Educational Neglect	Substantiated	Yes
	Deceased Child, Male, 14 Years	Father, Male, 42 Years	Educational Neglect	Substantiated	

Report Summary:
An SCR report alleged the child had a history of chronic absences from school. In the 2015-2016 school year, the child had been absent 26 days. As a result, the child was failing. The parents were aware and failed to intervene.

Report Determination: Indicated | **Date of Determination:** 08/01/2016

Basis for Determination:
The investigation was indicated as the parents did not encourage the child to attend school or complete his assignments. Additionally, the parents were aware the child was working during school hours. Although the child was enrolled in online-school, the child was not completing assignments. The record showed ACDCYF planned to file a Neglect Petition against the parents to obtain court ordered services, and a Family Services Stage would be opened.

OCFS Review Results:
ACDCYF contacted the source and initiated their investigation within 24 hours of receiving the SCR report. During the investigation, there was only one documented face to face contact with the family. The investigation was closed without assessing the child's safety for approximately 8 months. Some progress notes were entered more than 7 months after their event dates. The 7-day Safety Assessment was inaccurate and approved untimely.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:

Despite having had information the parents could not control the child's behavior, he did not attend school and was involved in illegal work activity, no safety factors were selected. Safety decision #2 should have been selected as safety factors existed but did not rise to the level of immediate or impending danger of serious harm. The Safety Assessment was approved three days after the due date.

Legal Reference:

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

Action:

ACDCYF will complete and approve all assessments timely and accurately. The Safety Assessments will reflect the Safety Factors that are present.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Some progress notes were entered more than 7 months after the event dates.

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.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

Although the child was seen once during the investigation, at the time of case closure, the child's safety had not been assessed for eight months.

Legal Reference:

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

Action:

ACDCYF will make 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 length of the investigation.

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

An SCR report opened from 11/03/15- 08/01/16 alleged educational neglect against the parents for the child. The report was substantiated.

Known CPS History Outside of NYS

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

Preventive Services History

A Family Services Stage was opened on 8/1/16, after the family was referred to services as a result of an indicated CPS investigation. The parents were aware the child did not attend school and was working during school hours, yet failed to intervene to meet his educational needs. Throughout the Family Services Stage, ACDCYF met with the child one time, and did not engage the father. The record did not reflect ongoing attempts to assess the child's safety. The FASPs were

consistently completed late and the case was closed on 5/19/17, due to the family's noncompliance. There was no documentation that a Neglect Petition was filed as planned and brought to Family Court.

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