

Report Identification Number: RO-18-017

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

Issue Date: Nov 13, 2018

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns: A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
The death of a child for whom child protective services has an open case.
The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
The death of a child for whom the local department of social services has an open preventive service case.

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

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

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

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

This report may <u>only</u> 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				
DrDoctor	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	ACS-Administration for Children's	NYPD-New York City Police				
Service	Services	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	<u> </u>					



Case Information

Report Type: Child Deceased Jurisdiction: Chemung Date of Death: 05/20/2018

Age: 15 year(s) Gender: Male Initial Date OCFS Notified: 05/20/2018

Presenting Information

The SCR report alleged on 5/20/18, SC, age 15, was found hanging from an electrical cord in his unfinished attic bedroom. He had no injuries other than the injuries to his neck caused by the electrical cord. It was unknown who found SC's body, but he was last seen alive at approximately 6:30 AM on 5/20/18. SC suffered from depression and was not in treatment and not believed to have been on any medication. SC's bedroom was in a deplorable state with animal feces all over the floor and exposed wiring. On the night of 5/19/18, SC expressed a desire to kill himself, but it was unknown if this information was communicated to SM, parent substitute (PS), or unrelated home member (UHM). The rest of the home had a foul odor due to animal feces on the floors which was not cleaned up and was a health hazard to the children. The three adults were named as alleged subjects for SC's death as he was in their care at the time of his death and the adults failed to address the conditions of the home.

Executive Summary

On 5/20/18, Chemung County Department of Social Services (CCDSS) received an SCR report regarding the death of the 15 yo SC. At the time of SC's death, CCDSS had an open Preventive Services case through Children's Integrated Services (CIS) for the UHM and her 5 children, ages 12 (OC1), 11 (OC2), 9 (OC3), 7 (OC4) and 3 (OC5). The case opened 11/21/17 and CCDSS was assisting UHM with managing the behaviors and MH concerns of OC1, OC2 and OC3. The SM, SC, 1 yo SS and the SS's BF (PS) were residing in the UHM's home and declined Preventive Services.

The investigation revealed on 5/20/18 around 3:30 PM, OC2 went upstairs to the attic and found SC hanging from a ceiling beam with an electrical cord wrapped around his neck. SM immediately called 911, although upon the arrival of LE, SC was determined to be deceased. All household members were in the home at the time of the incident and prior to the discovery, thought SC was sleeping in the attic.

An autopsy was performed by the Lourdes Hospital Department of Pathology. It was determined the manner of death was suicide and the cause of death was asphyxiation by hanging by the neck. SC was found to be an otherwise healthy child with injuries consistent with hanging. A joint investigation was conducted with LE. LE and CCDSS spoke to school staff, who expressed no concerns for SC's MH, said there were no red flags SC was suicidal and reported SC's friends expressed no concerns for SC. LE obtained SC's phone and attempted to gain access, although were unsuccessful. No criminal charges were filed and the LE investigation was closed.

CCDSS conducted a thorough investigation into the incident and contacted necessary collaterals. The home was assessed to contain safety hazards and the children did not have appropriate beds and bedding. After SC's death, SM and SS went to live with the MA and MU, and the SS was assessed to be safe throughout the investigation by Steuben County Department of Social Services (SCDSS). After the incident, UHM and her 5 children obtained emergency housing and did not return to the home. Despite ongoing efforts by CCDSS and multiple service providers, UHM failed to cooperate with Preventive Services, did not obtain permanent housing or income and failed to follow through with the necessary MH services for OC2. An Article 10 Neglect Petition was filed on 9/26/18 and was pending in Chemung County Family Court at the time this report was written.

CCDSS appropriately substantiated the allegations of IFCS against SM, PS and UHM regarding all 7 children based on the unsafe condition of the home. UHM was substantiated for IG regarding her 5 children and SC and LM regarding OC2 based on her failure to meet a minimum degree of care for the children. IG was substantiated against SM and PS regarding

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SC based on incidents of DV in which it was reported SC had to intervene. EdN was substantiated against SM regarding SC as SC had excessive absences and was failing several classes.

CCDSS unsubstantiated the allegations of DOA/Fatality and LM against SM, PS and UHM regarding SC. SC had no diagnosed MH condition or prior suicidal ideation or threats and SC's death was ruled suicide. LM was unsubstantiated against UHM regarding OC1 and OC3. Although UHM missed several MH appointments for OC1 and OC3, there was no apparent negative effect. Due to SS's age there was no apparent negative effect of the DV incidents or evidence of further maltreatment, therefore SM and PS were unsubstantiated for IG regarding SS. SM was referred for MH and grief counseling and SS was referred for Early Head Start services, although SM had not engaged in these services at the time the case was closed. The Preventive Services case remained open for UHM and her children with referrals for MH counseling, trauma counseling, housing assistance and financial assistance.

PIP Requirement

CCDSS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) CCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDSS 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:

O Approved Initial Safety Assessment? Yes

• Safety assessment due at the time of determination? Yes

• Was the safety decision on the approved Initial Safety Assessment Yes appropriate?

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, so gather allegations as well as any others identified in the course of the allegations.

Yes, sufficient information was gathered to determine all allegations.

• Was the determination made by the district to unfound or indicate Yes appropriate?

Explain:

The decision to Indicate the case and file an Article 10 Neglect Petition against UHM was appropriate.

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

Was casework activity commensurate with appropriate and relevant statutory Yes

or regulatory requirements?

Was there sufficient documentation of supervisory consultation?

Yes, the case record has detail of the

consultation.



Household

Child Fatality Report

Explain:

The case remained open for Preventive Services for UHM and her children.

	Required Actions Related to the Fat	ality				
Are there Require	d Actions related to the compliance issue(s)? Yes	□No				
Issue:	Adequacy of Documentation of Safety Assessments					
Summary:	The Investigation Determination safety assessment documented no safety plan or controlling					
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)					
Action:	The results of each safety assessment must be accuratel reflect case circumstances with regard to safety.	y documented in the case record in order to				
	Fatality-Related Information and Investi	gative Activities				
	·					
	Incident Information					
Date of Death: 05/2	20/2018 Time of Death	: 04:04 PM				
Time of fatal incid	ent, if different than time of death:	Unknown				
County where fata	lity incident occurred:	Chemung				
	mergency number called?	Yes				
Time of Call:		Unknown				
Did EMS respond		Yes				
	leading to death, had child used alcohol or drugs?	Unknown				
Child's activity at Sleeping Playing Other	Working Eating	☐ Driving / Vehicle occupant ☐ Unknown				
How long before in	ervision at time of incident leading to death? Yes acident was the child last seen by caretaker? 11 Hours a supervisor was: Not impaired.					
Children ages (eaths at incident event: 0-18: 1 ults: 0					
	Household Composition at time of Fa	tality				

Role

Gender

Age

Relationship



Deceased Child's Household	Deceased Child	Alleged Victim	Male	15 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Other Child - OC3	Alleged Victim	Female	9 Year(s)
Deceased Child's Household	Other Child - OC4	Alleged Victim	Male	7 Year(s)
Deceased Child's Household	Other Child - OC1	Alleged Victim	Male	12 Year(s)
Deceased Child's Household	Other Child - OC2	Alleged Victim	Male	11 Year(s)
Deceased Child's Household	Other Child - OC5	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	35 Year(s)
Other Household 1	Other Adult - BF of OC5	No Role	Male	40 Year(s)
Other Household 2	Other Adult - BF of OC1-OC4	No Role	Male	32 Year(s)

LDSS Response

CCDSS initiated the investigation by contacting the source and reviewing CPS history. It was learned SC had resided with different relatives, last residing with MGM's partner in Tennessee prior to moving in with SM in October 2017. SC had a history of marijuana use, a recent school suspension for smoking marijuana on school property and had no prior diagnosed MH concerns. CCDSS was unaware SC had been sleeping in the attic and there were no documented safety hazards at prior home visits. After reviewing CPS history, CCDSS immediately conducted a home visit, observed all household members and assessed the safety of the home. There were 7 children and 3 adults residing in the 4-bedroom home. There were blocked pathways, holes in walls, animal urine, dirt, garbage, old food and clothing throughout the home. Crisis MH services were present for the family. SM made a plan for her and SS to stay with a MA and MU in Steuben County. CCDSS assisted UHM and her children in obtaining temporary emergency housing.

SCDSS assessed SS to be safe with SM at MA and MU's home. SM stated there were never any signs SC was suicidal. MA and MU said SC resided with them for the month of April while on school suspension and they had no concerns for his MH. SM reported she had an argument with SC on 5/19/18, he took a walk, and seemed fine when he returned home. He went to bed around 3:00 AM and he usually slept late. PS was uncooperative with the investigation. SM alleged the BF of SC resided in Tennessee and paternity was never established. CCDSS contacted the alleged BF, although he denied paternity and had no information regarding SC.

UHM and her children were interviewed at the CAC. It was learned during SM and SC's argument on 5/19/18, SM yelled she wanted SC to move out of the house. SC left the home for a few hours and when he returned he had dinner and seemed fine. SC, OC1 and OC2 were in the attic talking until early morning. OC1 said SC tried to give him his cell phone, stating he didn't need it anymore. SC then threw the phone out the window. Around 3:00 AM, SC said he was going to smoke his last cigarette then leave. OC1 and OC2 thought SC meant run away and they didn't tell anyone, as they thought OC1 talked him out of it. Around 4:00 AM, SC told them to go to bed and it would be fine. UHM said she was awake when SC came downstairs for a drink around 4:00 AM and he went back upstairs. She and the children got up around 10:00 AM and they believed SC was just sleeping late, until OC2 went upstairs. OC2 reported going to the attic around lunchtime to check on SC and his head hit SC's feet hanging in the stairway. Concerns arose during the interviews and UHM agreed to supervise OC2 around other children. OC3 was referred to crime victim support services and a medical exam and OC2 was referred for a sexually acting out youth program. UHM had sole custody of her 4 oldest children and custody had not been established for OC5. The children did not have contact with the 2 BF and CCDSS' attempts to contact both BF were unsuccessful.

UHM and the children moved to different hotels and UHM did not cooperate with the Preventive Services case or follow RO-18-017 FINAL Page 6 of 15



through on referrals for housing, employment, and trauma services. CCDSS appropriately filed an Article 10 Neglect Petition against UHM to compel her to meet the children's MH and housing needs. In October 2018, UHM and the children's whereabouts were unknown and it was learned UHM may have moved to Pennsylvania. CCDSS was making diligent efforts to locate the family and the Preventive Services case remained open at the time this report was written.

At case closing, SM, PS and SS remained in the home of the MA and MU in Steuben County. CCDSS provided SM and PS with referrals for grief counseling, MH counseling and Early Head Start Services in Steuben County. CCDSS contacted the necessary collaterals to accurately determine all allegations and the case was appropriately indicated and closed.

Official Manner and Cause of Death

Official Manner: Suicide

Primary Cause of Death: From an injury - external cause

Person Declaring Official Manner and Cause of Death: Pathologist

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048087 - Deceased Child, Male, 15 Yrs	048090 - Unrelated Home Member, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated
048087 - Deceased Child, Male, 15 Yrs	048091 - Mother's Partner, Male, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048087 - Deceased Child, Male, 15 Yrs	048089 - Mother, Female, 38 Year(s)	Educational Neglect	Substantiated
048087 - Deceased Child, Male, 15 Yrs	048089 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048087 - Deceased Child, Male, 15 Yrs	048091 - Mother's Partner, Male, 34 Year(s)	Lack of Medical Care	Unsubstantiated
048087 - Deceased Child, Male, 15 Yrs	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
048087 - Deceased Child, Male, 15 Yrs	048091 - Mother's Partner, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
048087 - Deceased Child, Male, 15 Yrs	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048087 - Deceased Child, Male, 15 Yrs	048089 - Mother, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
048087 - Deceased Child, Male, 15 Yrs	048091 - Mother's Partner, Male, 34 Year(s)	DOA / Fatality	Unsubstantiated
048087 - Deceased Child, Male, 15 Yrs	048089 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated

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048087 - Deceased Child, Male, 15 Yrs	048089 - Mother, Female, 38 Year(s)	Lack of Medical Care	Unsubstantiated
048087 - Deceased Child, Male, 15 Yrs	048090 - Unrelated Home Member, Female, 35 Year(s)	Lack of Medical Care	Unsubstantiated
048092 - Sibling, Male, 1 Year(s)	048091 - Mother's Partner, Male, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
048092 - Sibling, Male, 1 Year(s)	048089 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048092 - Sibling, Male, 1 Year(s)	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048092 - Sibling, Male, 1 Year(s)	048091 - Mother's Partner, Male, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048092 - Sibling, Male, 1 Year(s)	048089 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
048093 - Other Child - OC1, Male, 12 Year(s)	048091 - Mother's Partner, Male, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048093 - Other Child - OC1, Male, 12 Year(s)	048090 - Unrelated Home Member, Female, 35 Year(s)	Lack of Medical Care	Unsubstantiated
048093 - Other Child - OC1, Male, 12 Year(s)	048089 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048093 - Other Child - OC1, Male, 12 Year(s)	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048093 - Other Child - OC1, Male, 12 Year(s)	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
048094 - Other Child - OC2, Male, 11 Year(s)	048091 - Mother's Partner, Male, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048094 - Other Child - OC2, Male, 11 Year(s)	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
048094 - Other Child - OC2, Male, 11 Year(s)	048090 - Unrelated Home Member, Female, 35 Year(s)	Lack of Medical Care	Substantiated
	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048094 - Other Child - OC2, Male, 11 Year(s)	048089 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048095 - Other Child - OC3, Female, 9 Year(s)	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
048095 - Other Child - OC3, Female, 9 Year(s)	048091 - Mother's Partner, Male, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048095 - Other Child - OC3, Female, 9 Year(s)	048090 - Unrelated Home Member, Female, 35 Year(s)	Lack of Medical Care	Unsubstantiated
048095 - Other Child - OC3, Female, 9 Year(s)	048089 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048095 - Other Child - OC3, Female, 9 Year(s)	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
	048089 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

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	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
1	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
048096 - Other Child - OC4, Male, 7 Year(s)	048091 - Mother's Partner, Male, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048097 - Other Child - OC5, Male, 3 Year(s)	048089 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
048097 - Other Child - OC5, Male, 3 Year(s)	048091 - Mother's Partner, Male, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
1	048090 - Unrelated Home Member, Female, 35 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	\boxtimes			
When appropriate, children were interviewed?	\boxtimes			
Alleged subject(s) interviewed face-to-face?	\boxtimes			
All 'other persons named' interviewed face-to-face?	\boxtimes			
Contact with source?	\boxtimes			
All appropriate Collaterals contacted?	\boxtimes			
Was a death-scene investigation performed?	\boxtimes			
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?	\boxtimes			
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?	\boxtimes			
Was there an adequate assessment of impending or immediate danger to shousehold named in the report:	urviving	siblings/o	ther child	lren in the
Within 24 hours?	\boxtimes			
At 7 days?	\boxtimes			

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Was there legal activity as a result of the fatality investigation?				
Legal Activity Related to the Fatality				
Logal Activity Deleted to the Estality				
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?		\boxtimes		
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?		\boxtimes		
	Yes	No	N/A	Unable to Determine
Placement Activities in Response to the Fatality Invo	estigatio	n		
Explain: The appropriate service needs were identified for UHM and her children and an amandate those services.	Article 1	10 Neglec	t Petition	was filed to
Were appropriate/needed services offered in this case	\boxtimes			
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?				
Was there an adequate assessment of the family's need for services?				
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	\boxtimes			
Was the risk assessment/RAP adequate in this case?	\boxtimes			
	Yes	No	N/A	Unable to Determine
Fatality Risk Assessment / Risk Assessment Pro	ofile			
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?	\boxtimes			
Are there any safety issues that need to be referred back to the local district?				
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?				
At 30 days?				

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Date Filed:	Fact Finding Description:	Disposition Description:
09/26/2018	There was not a fact finding	There was not a disposition
Respondent:	048090 Unrelated Home Member Female 35 Year(s)	
Comments:	An Article 10 Neglect Petition was filed against UHM Court.	I regarding her children and was pending in Family

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		\boxtimes					
Economic support							
Funeral arrangements							
Housing assistance							
Mental health services							
Foster care						\boxtimes	
Health care		\boxtimes					
Legal services							
Family planning							
Homemaking Services							
Parenting Skills							
Domestic Violence Services							
Early Intervention		\boxtimes					
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:

OC3 was referred for crime victim support services. UHM and her children were provided with emergency housing assistance and referred to trauma counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

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SM was referred for MH and grief counseling, although had not yet engaged in these services. UHM and her children were provided with housing assistance.

History Prior to the Fatality

Child Information

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

Was there an open CPS case with this child at the time of death?

No
Was the child ever placed outside of the home prior to the death?

No
Were there any siblings ever placed outside of the home prior to this child's death?

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	Complian Issue(s)
02/02/2018	Other Child - OC5, Male, 3 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	No
	Other Child - OC4, Male, 7 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC3, Female, 9 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC1, Male, 12 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 15 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC5, Male, 3 Years	Unrelated Home Member, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC4, Male, 7 Years	Unrelated Home Member, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC3, Female, 9 Years	Unrelated Home Member, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC1, Male, 12 Years	Unrelated Home Member, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC2, Male, 11 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC2, Male, 11 Years	Unrelated Home Member, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 15 Years	Unrelated Home Member, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC5, Male, 3 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

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Other Child - OC4, Male, 7 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - OC3, Female, 9 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - OC1, Male, 12 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 15 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - OC3, Female, 9 Years	Unrelated Home Member, Female, 34 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - OC2, Male, 11 Years	Unrelated Home Member, Female, 34 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - OC1, Male, 12 Years	Unrelated Home Member, Female, 34 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - OC2, Male, 11 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - OC5, Male, 3 Years	Unrelated Home Member, Female, 34 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - OC4, Male, 7 Years	Unrelated Home Member, Female, 34 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 15 Years	Child, Male, Unrelated Home Member, Female, 34 Years Inadequate Food / Clothing / Shelter Unsubstantiate		Unsubstantiated

Report Summary:

An SCR report alleged OC1 and OC2 had behavioral issues. The adults hit the children and threatened them with belts and foul language. The adults yell and scream at one another, as well as the children. The home was in deplorable condition with dirty clothing everywhere and animal feces on the floor.

Report Determination: Unfounded Date of Determination: 05/07/2018

Basis for Determination:

CCDSS unsubstantiated the allegations against SM and UHM regarding the children. The home was observed to contain no safety hazards. All household members denied the children were physical disciplined and the children were observed to have no marks or bruises. Several of the children had special needs with MH and behavioral concerns. The children's needs were being addressed in MH counseling and through an open Preventive Services case.

OCFS Review Results:

The home was properly assessed for safety, all household members were interviewed and all necessary collateral contacts were made. Notice of Existence letters were provided to the necessary adults. BFs of the children were appropriately added to the case and attempts were made to locate and notify them of the report. Safety assessments were completed on time and were accurate. Service needs were adequately assessed and no additional service needs were identified. The case appropriately remained open for Preventive Services.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/25/2018	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	Inadequate Food / Clothing / Shelter	Far-Closed	No

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Unrelated Home Member,	Inadequate	Far-Closed	
•	<u> </u>		
1	1 *	Far-Closed	
	Guardianship		
	Inadequate	Far-Closed	
Female, 34 Years	Guardianship		
Unrelated Home Member,	Inadequate Food /	Far-Closed	
Female, 34 Years	Clothing / Shelter		
<u> </u>		Far-Closed	
1	1 *		
		Far-Closed	
1			
· ·	Inadequate Food /	Far-Closed	
1	1 *		
•	+	Far-Closed	
1			
· · · · · · · · · · · · · · · · · · ·		Far-Closed	
	1 *		
	+		
1	1 *	Far-Closed	
	-		
Mother's Partner, Male, 34	1 *	Far-Closed	
Years	Guardianship		
Unrelated Home Member,	Inadequate	Far-Closed	
Female, 34 Years	Guardianship		
	<u> </u>		
1		Far-Closed	
<u> </u>	_		
	1 *	Far-Closed	
remaie, 34 rears			
Mother, Female, 37 Years		Far-Closed	
, ,	-		
Mother Female 37 Years	1 *	Far-Closed	
2.25 3121, 1 2111410, 5 / 1 2415	-	rai-Closed	
Mother Female 37 Vegra	Inadequate	Far-Closed	
ivionici, i cinaic, 3/ i cais	Guardianship	rar-Closed	
	Female, 34 Years Unrelated Home Member, Female, 34 Years Mother's Partner, Male, 34 Years Mother's Partner, Male, 34 Years Mother's Partner, Male, 34 Years	Female, 34 Years Unrelated Home Member, Female, 34 Years Mother's Partner, Male, 34 Years Mother's Partner, Male, 34 Years Unrelated Home Member, Female, 37 Years Mother, Female, 37 Years Mother Female, 37 Years Undequate Guardianship Inadequate	

Report Summary:

An SCR report alleged the home was chaotic; the adults were often screaming, yelling and threatening to hit the children. OC1 and OC2 had behavioral issues, were trying to get into other people's homes an done of the boys threw a kitten against a wall. The adults in the home were home at the time. The adults hit the children and are excessive. It was unknown if any of the children sustained any injuries. A subsequent report was received on 1/25/2018 and merged with similar concerns as well as additional concerns for the condition of the home.

OCFS Review Results:

The case was tracked FAR upon receipt. CCDSS spoke to the source of the reports and the service provider for the UHM and her children. UHM was spoken to over the phone and an appointment was scheduled for 1/29/2018. UHM took 4 of her children out of state to visit family and did not return home due to her car breaking down. CCDSS spoke to UHM on the phone again on 1/31/2018 and interviewed the SC and OC3 at school on 2/1/2018. SC had no safety concerns for any



of the children in the home. Several attempts to conduct home visits and to make additional contact with the UHM were
unsuccessful. The case closed on 2/7/2018 due to the family's lack of cooperation and a new SCR report was made.
Are there Required Actions related to the compliance issue(s)? Yes No
CPS - Investigative History More Than Three Years Prior to the Fatality
There is no CPS history more than 3 years prior to the fatality.
Known CPS History Outside of NYS
There was a CPS case in 2015 in Pennsylvania against UHM regarding lack of supervision of her children and the home was observed to be cluttered with garbage and to have a foul odor. The case was unfounded due to a lack of credible evidence and the case was closed as the family moved and was unable to be located.
Preventive Services History
A voluntary Preventive Services case was opened 11/21/17 regarding UHM and her 5 children. The school referred the family for services due to OC3 having behavioral issues at school and at home. UHM also reported behavioral and MH concerns for OC1 and OC2. OC2 and OC3 were enrolled in a school based therapy program with Family Services and a referral was sent for OC1 to engage in a support program with Glove House. PS, SM, SC and SS were residing in the nome, although were not part of the services case.
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

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