Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-18-031

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

Issue Date: Jan 07, 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: 1 year(s)
Jurisdiction: Cayuga
Gender: Male
Date of Death: 07/11/2018
Initial Date OCFS Notified: 07/12/2018

Presenting Information

An SCR report received on 07/12/2018 alleged on 07/03/18 at approximately 10:30AM, the mother failed to provide the child with adequate supervision. The mother was cleaning and thought the 12yo sibling was supervising the child and his 1yo twin. The 7yo SS was in another room, not supervising the children. The child left the home and wandered outside. The child crawled through a missing gate spindle which blocked the entryway to the above ground pool. The child was missing for about 10 minutes before the 7yo SS found him unresponsive floating in the pool. She was unable to get the SC out of the pool. The mother pulled the child from the pool and attempted CPR until EMS responded. The child was taken to the hospital for treatment. On 07/11/18, the child died at the hospital. The child had no known visible injuries. The SS, aged 2, 7, 8, 14 and 16 years, maternal aunt, and fathers of the children had unknown roles.

Executive Summary

This report concerns the death of the two-year-old male subject child (SC), who died during an open Family Assessment Response case involving parental substance abuse, lack of ample food for the family and unsanitary living conditions. Additionally, the home had an alleged bedbug infestation and the children had infected bug bites.

On 07/03/18, the mother failed to provide adequate supervision of her two-year-old child and as a result, the child was found unresponsive in the family's pool. The child was hospitalized and pronounced deceased on 07/10/18. On 07/12/18, Cayuga County Department of Social Services (CCDSS) received an SCR report regarding the child's death.

EMS responded to the scene on the morning of the fatal incident, resuscitated the SC and transported him to the hospital. He was then airlifted to another hospital, due to his condition. The child soon had no brain activity, experienced kidney failure and passed away.

An autopsy was performed and the medical examiner determined the manner of death to be accidental and the cause of death "brain injury due to fresh water drowning."

CCDSS worked jointly with LE during the investigation. LE found no criminality during their investigation and no arrests were made. CCDSS obtained law enforcement records, including statements from witnesses and EMS.

CCDSS assessed the safety of the home and the surviving siblings multiple times throughout the investigation. Relevant collateral sources were contacted, and no concerns were noted.

CCDSS offered services to the family including mental health counseling, bereavement counseling, a drug and alcohol evaluation, Preventive Services and assistance in obtaining pool safety equipment. The mother accepted Preventive Services for the family and a case was opened to work with the family while they processed the trauma they experienced.

CCDSS did not document completing a full safety and risk assessment of the children with the maternal aunt, including inquiring if she had any concerns regarding the supervision of the children, or the mother's ability to care for them.

Although the father of the children was made aware of the investigation, he was unable to contribute any additional information regarding the mother's parenting, or the safety of the surviving siblings in her care as he didn't have any contact with the family. The record did not show documentation that he was offered any services relating to the fatality.

In reviewing the family's CPS history in preparation of this report, there were issues identified with CCDSS's adherence to approved practice surrounding FAR cases. OCFS has taken action to provide administrative support, to be provided in conjunction with the Syracuse Regional Office. Additionally, CCDSS has discontinued their FAR program indefinitely.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
Casework activity was commensurate with case circumstances and the allegations were appropriately determined.

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:
A Family Services Stage was opened to assist the family in obtaining Services through CCDSS and other community resources.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	Within 24 hours of receiving the SCR report, the safety of 3 surviving siblings was assessed; however, only information regarding the whereabouts of the other 3 children was documented and did not include an assessment of safety.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)

Child Fatality Report

Action:	CCDSS will adequately assess safety of children respective to case circumstances within 24 hours of each SCR report and document the information within Connections.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/11/2018 **Time of Death:** 10:55 AM

Date of fatal incident, if different than date of death: 07/03/2018
Time of fatal incident, if different than time of death: 10:30 AM

County where fatality incident occurred: Cayuga
Was 911 or local emergency number called? Yes
Time of Call: 10:39 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was: Unknown if they were 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	Aunt/Uncle	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Female	16 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	12 Year(s)
Other Household 1	Father	No Role	Male	41 Year(s)
Other Household 2	Father	No Role	Male	42 Year(s)

Other Household 2	Other Adult - BF of SS1-SS5	No Role	Male	28 Year(s)

LDSS Response

CCDSS received an SCR report on 07/12/18, regarding the death, and immediately coordinated investigative efforts into the death with LE, who had already begun a criminal investigation.

Within 24 hours of receiving the SCR report, CCDSS attempted to assess the safety of the surviving siblings by contacting their parents, maternal aunt and family friend. CCDSS was able to assess the safety of 3 of the surviving siblings immediately after receiving the report; however, the case record did not include information regarding the safety of the other 3 surviving siblings at that time. A review of CPS history was completed for the family timely.

During the investigation, CCDSS assessed the safety of the children multiple times and spoke to them about the fatal incident; however, no new information was obtained as LE had already questioned the family prior to the death. Additionally, CCDSS contacted the ME, and made home visits to both parent's homes, and the home of a family friend.

According to LE records, the SC wandered out of his home, presumably walked over a baby gate laying on the stairs and fell into the family's pool around 10:30AM. Interviews with the family revealed that the mother was cleaning in another room, leaving the 12yo and 7yo siblings to care for the twins. The 12yo SS left the room for approximately 10 minutes before noticing the SC was no longer in the room where she had left him. Immediately, the 7yo SS found the door to the outside open. The door was alleged to have been left open by a child the mother was babysitting that day, who was upstairs with the 8yo SS at the time of the fatal incident.

The 12yo SS and the 7yo SS began to look for the missing child, and found him floating face up in the pool. The 7yo SS jumped into the pool to assist her brother, but needed help from the 12yo SS. Together, the children pulled the SC from the pool, and the mother immediately ran outside when she heard the siblings screaming.

Witness statements included information that a neighbor and passersby heard screaming and were told that a baby fell into a pool. The passersby ran to the yard to find the mother hunched over the child screaming "save my baby!" The child was described to be pulseless, limp, unconscious and not breathing. Additionally, he was foaming at the eyes, nose and mouth. Through the commotion, the passersby contacted 911 and began resuscitation efforts until EMS and LE arrived a short time later.

EMS took over resuscitation efforts while transporting the child to the hospital, and the child was in cardiac arrest. The child was revived, but required breathing and feeding tubes. He was described by medical professionals to have a severe anoxic brain injury and a submersion injury because of drowning. The child was in respiratory failure and was pronounced brain dead on 7/10/18; however, he was kept on life support for organ donation, and was pronounced deceased the following day at 10:55AM.

The 16yo SS and 14yo SS and the maternal aunt, who owned the home, were not home during the fatal incident and could not provide additional information.

Further investigation into the incident revealed the family's pool violated several local ordinances including improper fence barriers, improper railing spindles and improper self-closing, self-latching at the bottom of the pool deck stairs. Additionally, the pool's ladder was found at the bottom of the pool. The Code Enforcer cited the maternal aunt regarding these issues. The family was noted to set up new rails, installed a lock on the fate, and installed a pool alarm.

Prior to the investigation concluding, the mother, and four of the SS (ages 2, 7, 8, and 12 years) moved to a new residence and the home was assessed to be safe for the family. The 16yo SS and 14yo SS decided to continue to live with their maternal aunt, which was deemed appropriate by CCDSS.

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: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Cayuga County Department of Social Services does not have an OCFS-approved Child Fatality Review Team at this time.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047013 - Deceased Child, Male, 1 Yrs	047014 - Mother, Female, 34 Year(s)	Lack of Supervision	Substantiated
047013 - Deceased Child, Male, 1 Yrs	047014 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
047013 - Deceased Child, Male, 1 Yrs	047014 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated
047013 - Deceased Child, Male, 1 Yrs	047806 - Aunt/Uncle, Female, 43 Year(s)	Inadequate Guardianship	Substantiated
047809 - Sibling, Female, 12 Year(s)	047014 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
047810 - Sibling, Female, 7 Year(s)	047014 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
047813 - Sibling, Female, 1 Year(s)	047014 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
047813 - Sibling, Female, 1 Year(s)	047014 - Mother, Female, 34 Year(s)	Lack of Supervision	Substantiated
047813 - Sibling, Female, 1 Year(s)	047806 - Aunt/Uncle, Female, 43 Year(s)	Inadequate Guardianship	Substantiated

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?	☐	☒	☐	☐
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:
Although medical records were received and LE statements were obtained, there was no documentation CCDSS had communication the passersby who assisted in CPR and called 911.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☒	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Explain:
Although a home visit was made and the whereabouts for the surviving siblings was known, there was no documentation regarding the safety of the children.

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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:
The family was offered an array of services through a Family Support Program and a Family Preservation Program. The mother was hesitant and wished to grieve alone; however, accepted the services.

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:
A multitude of Services were offered to the mother and surviving siblings. The family was accepting of mental health counseling. The family was offered additional services through a Family Support Program.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The family was accepting of mental health counseling, and the mother declined drug/alcohol counseling. The maternal aunt was offered grief counseling. Although the father did not have any prior involvement with his children (SC and his twin), he may have benefited from support services, but there was no documentation he was offered any services in response to 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)	Status/Outcome	Compliance Issue(s)
06/22/2018	Deceased Child, Male, 1 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Male, 1 Years	Other Adult - Unknown, Male, 28 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 8 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 8 Years	Other Adult - Unknown, Male, 28 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 1 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 1 Years	Other Adult - Unknown, Male, 28 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 7 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 7 Years	Other Adult - Unknown, Male, 28 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 12 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 12 Years	Other Adult - Unknown, Male, 28 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 14 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 14 Years	Other Adult - Unknown, Male, 28 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 16 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 16 Years	Other Adult - Unknown, Male, 28 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 14 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 7 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 16 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 8 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 12 Years	Other Adult - Unknown, Male, 28 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 14 Years	Mother, Female, 34 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 14 Years	Mother, Female, 34 Years	Lacerations / Bruises / Welts	Far-Closed	

Sibling, Female, 14 Years	Mother, Female, 34 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Deceased Child, Male, 1 Years	Mother, Female, 34 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Deceased Child, Male, 1 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Far-Closed
Sibling, Male, 8 Years	Mother, Female, 34 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Male, 8 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Far-Closed
Sibling, Female, 1 Years	Mother, Female, 34 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Female, 1 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Far-Closed
Sibling, Female, 7 Years	Mother, Female, 34 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Female, 7 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Far-Closed
Sibling, Female, 12 Years	Mother, Female, 34 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Female, 12 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Far-Closed
Sibling, Female, 14 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Far-Closed
Sibling, Female, 16 Years	Mother, Female, 34 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Female, 16 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Far-Closed
Deceased Child, Male, 1 Years	Mother, Female, 34 Years	Inadequate Guardianship	Far-Closed
Sibling, Female, 1 Years	Mother, Female, 34 Years	Inadequate Guardianship	Far-Closed

Report Summary:
An SCR report received on 06/22/18 alleged the mother and another adult, had a history of abusing drugs. There was often not enough food in the home due to household money being used to purchase drugs. As a result, all of the children missed meals. The 15yo sibling was hit by the mother when she complained about the lack of food; she sustained bruising. The home was dirty and had a bed bug infestation. As a result, the 7yo and 8yo siblings had infected and swollen bug bites. The adults did nothing to treat the children's bed bug bites. It was unknown if the other children had bites. The role of the father was unknown.

OCFS Review Results:
CCDSS tracked the case FAR, despite the allegation of LA/BW which made the report ineligible. CCDSS did not document conversations with the family addressing possible safety and risk factors, and the CPS history check and Notices of FAR were not provided timely. CCDSS did not address concerns presented by the family. The family was not engaged together during the FAR case. CCDSS reported a subject of the SCR report in error, and did not clearly document their reasoning for doing so.

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

Issue:
FAR-Inappropriate Determination of CPS/FAR Track
Summary:
The report was tracked FAR despite being ineligible due to the allegation of LA/BW being presented at the time of the SCR intake.
Legal Reference:
18 NYCRR 432.13 (c); 18 NYCRR 432.13(e)(2)(ii)(a-d)
Action:
CCDSS stopped tracking cases to FAR in October 2018, and they have no intention of re-engaging in the FAR Program; therefore, no Program Improvement Plan is required.

Issue:
FAR-Failure to Address Reported or Identified Concerns
Summary:
The mother's alleged partner was a subject of the report and was not attempted to be interviewed during the FAR case, despite being identified. Additionally, he was improperly reported in error. There was not documentation all of the family members were interviewed regarding reported concerns, including drug use and supervision.
Legal Reference:
18 NYCRR 432.13 (a)(3)(iii)
Action:
CCDSS stopped tracking cases to FAR in October 2018, and they have no intention of re-engaging in the FAR Program; therefore, no Program Improvement Plan is required.

Issue:
FAR-Timely/Adequate Family-Led Assessment Guide
Summary:
There was not documentation the FLAG was completed with the family and the questions within the FLAG were not addressed with the family. The FLAG was approved 3 days after the due date.
Legal Reference:
18 NYCRR 432.13 (e)(2)(iii)-(v)
Action:
CCDSS stopped tracking cases to FAR in October 2018, and they have no intention of re-engaging in the FAR Program; therefore, no Program Improvement Plan is required.

Issue:
FAR-Overall Completeness/Adequacy of Family Assessment Response
Summary:
During the FAR case, the family was never engaged together and reported concerns were not always addressed, nor were possible solutions offered to the family regarding the reported concerns such as the mother being "overwhelmed". CCDSS did not adhere to regulations regarding FAR practice or casework practice.
Legal Reference:
18 NYCRR 432.13 (a)(1-4)
Action:
CCDSS stopped tracking cases to FAR in October 2018, and they have no intention of re-engaging in the FAR Program; therefore, no Program Improvement Plan is required.

Issue:
FAR-Failure to Engage the Family
Summary:

During the FAR case, the family was not documented to have been spoken with together regarding the concerns. Some interviews with the children were completed privately, and the family was not engaged as a whole.

Legal Reference:

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

Action:

CCDSS stopped tracking cases to FAR in October 2018, and they have no intention of re-engaging in the FAR Program; therefore, no Program Improvement Plan is required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/26/2017	Sibling, Female, 13 Years	Mother, Female, 32 Years	Lack of Supervision	Far-Closed	Yes
	Sibling, Female, 13 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 5 Years	Mother, Female, 32 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 5 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 6 Months	Mother, Female, 32 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 6 Months	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 15 Years	Mother, Female, 32 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 15 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 10 Years	Mother, Female, 32 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 10 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Deceased Child, Male, 6 Months	Mother, Female, 32 Years	Lack of Supervision	Far-Closed	
	Deceased Child, Male, 6 Months	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 7 Years	Mother, Female, 32 Years	Lack of Supervision	Far-Closed	
	Sibling, Male, 7 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:

An SCR report received on 1/26/17 alleged the mother regularly went to bars and came home intoxicated. As a result, she was unable to wake up in the morning and provide supervision for her children. The 15yo SS went to the hospital for a concussion, details were unknown. The 11yo and 13yo SS were left to care for the younger siblings, ages 5yo, 7yo and 6-month old twin siblings. Caring for the CHN was beyond what they are capable of. The 7yo SS exhibited violent behaviors, and left marks on siblings. The 7yo SS set fire to a bed. SM was home for this, but did not wake until smoke filled the home. The SM continued to abuse alcohol and failed to provide or arrange safe supervision for her CHN.

OCFS Review Results:
CCDSS initiated their response in accordance with FAR protocols. Notice of Existence letters were provided in a timely manner. Concerns regarding parent drug and alcohol misuse, lack of supervision, and inadequate food revealed during the FAR case were not documented to be appropriately addressed with the family.

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

Issue:
FAR-Failure to Address Reported or Identified Concerns

Summary:
During the FAR case, CCDSS was presented with concerns regarding the mother's L/S, PD/AM, and IFCS through family members and collateral contacts. CCDSS did not document addressing the concerns with the family in detail after the information was presented. Documentation of interviews with the family were lacking detail.

Legal Reference:
18 NYCRR 432.13 (a)(3)(iii)

Action:
CCDSS stopped tracking cases to FAR in October 2018, and they have no intention of re-engaging in the FAR Program; therefore, no Program Improvement Plan is required.

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
Multiple progress notes were not entered contemporaneously during the FAR case, and were documented 11 weeks after the event date.

Legal Reference:
18 NYCRR 428.5

Action:
All progress notes will be entered as contemporaneously as possible to their event dates.

Issue:
FAR-Insufficient Number of Casework Contacts

Summary:
The FAR case was open for longer than 90 days and there was no documentation regarding the decision to keep the case open or specific goals and steps to achieve those goals.

Legal Reference:
18 NYCRR 432.13 (e)(4); 18 NYCRR 432.13 (e)(3)(v)(d)(2)

Action:
CCDSS stopped tracking cases to FAR in October 2018, and they have no intention of re-engaging in the FAR Program; therefore, no Program Improvement Plan is required.

Issue:
FAR-Improper Case Closure

Summary:
The FAR case was open for 104 days and there was not documentation regarding the need for the case to remain open.

Legal Reference:
18 NYCRR 432.13 (e)(3)

Action:
CCDSS stopped tracking cases to FAR in October 2018, and they have no intention of re-engaging in the FAR Program; therefore, no Program Improvement Plan is required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/10/2016	Sibling, Male, 6 Years	Mother, Female, 32 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Male, 6 Years	Mother, Female, 32 Years	Lack of Supervision	Far-Closed	
	Sibling, Male, 6 Years	Other Adult - BF of SS1-SS5, Male, 32 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 6 Years	Other Adult - BF of SS1-SS5, Male, 32 Years	Lack of Supervision	Far-Closed	

Report Summary:
An SCR report alleged on 6/10/17, The father had the 7yo SS for visitation. The father dropped the child off at his mother's home around 8:20PM by walking into the mother's home and left the child, assuming the mother was there, due to lights being on; however, the mother was not home. The 7yo SS was left home alone and unattended and was crying. The mother and father are both culpable for leaving the child home alone and unattended due to lack of communication.

OCFS Review Results:
The family was engaged to gather information to complete the FLAG, which was completed accurately. The 7-day Safety Assessment was completed timely and accurately. Information was revealed that the children do not visit their father due to the father hitting them on their backs, buttocks, and faces. Family members were not asked if the children ever sustained marks or bruises as a result of the father hitting them, or if they were fearful. During the FAR response, the children were observed to be without supervision on several occasions, but there was not documentation of the children's ability to care for themselves or others without an adult present.

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

Issue:
FAR-Failure to Address Reported or Identified Concerns

Summary:
The family was not engaged in conversation regarding whether the children were fearful of their father, or if they sustained LA/BW as a result of the father hitting them. Furthermore, the children were observed by CCDSS on several occasions to be unsupervised and there is not documentation of an assessment of the children's ability to care for themselves or the younger children.

Legal Reference:
18 NYCRR 432.13 (a)(3)(iii)

Action:
CCDSS stopped tracking cases to FAR in October 2018, and they have no intention of re-engaging in the FAR Program; therefore, no Program Improvement Plan is required.

[redacted]

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

05/03/11-05/11/11 UNF against BF of SS1-SS5 for IG and LA/BW regarding SS1.

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