Child Fatality Report

Report Identification Number: AL-17-003

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

Issue Date: Jun 08, 2017

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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Fulton
Gender: Female
Date of Death: 03/05/2007
Initial Date OCFS Notified: 01/10/2017

Presenting Information

The SCR report alleged SM had a history of abusing drugs. A couple of years ago, the SM was under the influence of pills and cocaine while caring for an infant (SC). The SM laid down next to the infant in bed and rolled over onto her, smothering her to death. The SM spent her money on drugs and did not have adequate supplies for the SC, nor a crib for her to sleep in.

Executive Summary

An SCR report was received by Fulton County Department of Social Services (FCDSS) on 1/10/17 concerning the death of the SC. It was alleged the SM was responsible for the death of the female SC, who was 2 months old at the time of her death. The SC died on 3/5/07, and FCDSS began investigating the SM's role with respect to the fatality.

The SC's death was previously investigated by FCDSS and LE beginning on 3/6/07 in response to an SCR report alleging the SM and BF were responsible for the death after bed sharing with the SC. During the 2007 investigation, FCDSS interviewed everyone present in the home at the time of the fatality as well as other family members. FCDSS assessed the safety of the SS, who was then 2 y/o, as well as an OC in the household, who was then 11 y/o. The SM provided an account of when she last saw the SC alive which was inconsistent with the ME's evaluation of the approximate time of death. The SM and BF eventually stated the 3 of them were in the same bed at the time of the fatality. There were no related arrests, and LE closed their case ruling the death a "lay-over." Prior to her death, the SC had a common infant illness and had been given remedies, but this was unrelated to the death. The ME declared in the final autopsy report that the cause of death was unable to be determined, noting a history of co-sleeping with adults.

FCDSS adequately investigated the fatality again beginning on 1/10/17. FCDSS pulled forward all pertinent information from the previous investigation, investigated newly reported concerns of drug misuse, contacted collaterals, and attempted to re-interview all parties who were present at the time of SC's death.

FCDSS found no credible evidence that the SM was impaired by substances at the time of the fatality; however, they did find credible evidence that the SM placed the SC at significant risk of serious harm/death by bed sharing in conjunction with the presence of aggravating factors – a small bed, several blankets and pillows, and two adults. Such factors exacerbated the risk of death. This finding was based on evidence from the 2007 investigation, including photographs of the scene.

FCDSS evaluated the circumstances of the SS to assess safety within 24 hours. In addition to the now 11-year-old SS, two SS were born after SC's death, now ages 7 and 8. There were also 2 SS, now ages 15 and 16, who were half siblings by the BF and never had any contact with the SC. At the time of this investigation, the SM had no contact with any of these children. The 11 and 7 y/o SS were in the custody of the MGM, and SM had not visited with them in over a year. The SM surrendered her rights to the 8 y/o SS in 2010, and there was reportedly no contact between them as well.

FCDSS conducted a complete investigation and re-evaluated the previous UNF determination from 2007. FCDSS

documented there had been some credible evidence at that time to IND SM for the death of the SC, and used that information as the basis to IND the new report.

A previous fatality report was issued by OCFS Albany Regional Office on 7/29/08. FCDSS was cited for an incomplete investigation and improper determination as to the nature, extent, and cause of the condition(s) enumerated in the original report. In response, a Corrective Action Plan (CAP) was implemented to address the cited issues. In review of whether those issues were recurring following the implementation of the CAP, it appears FCDSS has made improvements in those areas.

OCFS' review of CPS history revealed some citations related to casework practice. In response, FCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) FCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, FCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

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 level of casework activity was commensurate with case circumstances, and the record reflects detailed conversations with supervision.

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: 03/05/2007 **Time of Death:** 07:00 AM

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

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

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Other Adult	No Role	Male	37 Year(s)
Deceased Child's Household	Other Adult	No Role	Female	32 Year(s)
Deceased Child's Household	Other Child	No Role	Male	11 Year(s)
Other Household 1	Grandparent	No Role	Female	39 Year(s)
Other Household 1	Sibling	No Role	Male	2 Year(s)

LDSS Response

FCDSS promptly initiated an investigation and reviewed all pertinent notes and records from the 2007 investigation. FCDSS inquired of LE if they were interested in another joint investigation; they were not, due to the amount of time that had passed and the previously determined non-criminal nature of the fatality. FCDSS reviewed the circumstances of the fatality with the SM, MGM, MGF, and an adult and child who were present in the home at the time of the fatality. The person who was a child in the home at the time of the fatality was 21 y/o at the time of the interview in the new investigation. Efforts were made to interview another adult who was present in the home at the time of the fatality, to no avail. FCDSS was unable to re-interview the BF, as he passed away in 2009. FCDSS attempted to coordinate a face-to-face interview with the SM, but their diligent efforts were unsuccessful.

In their review of history and conversations with the SM and MGM, FCDSS determined safety for all of the SS. They were deemed safe because they had not had any contact with SM in over on year. At the time of the fatality, the only child present in the home was an 11 y/o relative of the MGF. He did not have information regarding the specifics of events leading up to the fatality, when interviewed in both investigations. The then 2 y/o SS had resided with the MGM at the time of SC's death, and due to his age/developmental level, he could not be interviewed at that time. The two half-siblings resided with their BM at the time of the fatality and had never had contact with the SC. All but one SS had the same BF.

From their interviews, collateral contacts, and review of evidence, FCDSS did not uncover any new information regarding the fatality. In the 2007 investigation, the SM gave varying accounts of the last time she saw the SC alive and the manner in which the SC was placed to sleep on the day she died. For these reasons, much was still unknown regarding the specifics of the events leading up to the fatality. The SC's blood had been found on the front and back of the SM's shirt, and there was evidence of an unsafe sleep environment with a confirmed history of parental bed sharing with the infant, in addition to the presence of aggravating factors. The BF was also deaf, furthering the risk of bed sharing. The family confirmed the SC's normal sleeping arrangements were either in bed with the parents or in a car seat. Prior to her death, the SC had been given over-the-counter and prescription medications for a common infant illness. The SM was the one to discover the child non-responsive after waking up, and 911 was called while efforts were made by the family to resuscitate the SC. Evidence indicated the SM was educated on safe sleep practice prior to the SC's death.

The SM, BF, and other family members were questioned whether there was drug or alcohol use at the time of the fatality, and FCDSS found no evidence that this was a concern. This was a new allegation in the current report, so FCDSS inquired again and found no evidence to substantiate the claim.

Since the fatality, the SM has been an alleged subject on numerous reports concerning her children and unrelated children when she resided in several different households. A child born after the fatality was removed from her care, as one of the concerns included bed sharing despite the fact, as noted, that she had a previous child death due to bed sharing (referencing the SC).

FCDSS adequately determined all allegations based on their review and reassessment of the 2007 investigation as well as made diligent efforts to gather any potentially new information.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Comments: The investigation was conducted by an MDT. FCDSS adhered to previously approved protocols for joint investigations and attempted to coordinate an investigation with LE, though LE declined as they had previously investigated the death in 2007.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No

Comments: There is not an OCFS approved CFRT in Fulton County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
034957 - Deceased Child, Female, 2 Mons	034958 - Mother, Female, 19 Year(s)	DOA / Fatality	Substantiated
034957 - Deceased Child, Female, 2 Mons	034958 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated
034957 - Deceased Child, Female, 2 Mons	034958 - Mother, Female, 19 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☒	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

Efforts were made to interview SM face-to-face & others present at the time of the death. No effort was made to interview the other adult named, determining him as reported in error based on SM's denial of his involvement. SS had not yet been

born.

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 safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐
When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

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

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Explain as necessary:
MGM obtained physical custody of 2 SS by an agreement of the biological parents. Another SS born after the fatality was removed for protective reasons, remained in foster care, and was adopted after SM's rights were surrendered. A question in the RAP was wrong, stating SM's rights had been terminated when in fact they had been surrendered.

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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:
SM informed FCDSS she was actively engaged in her own MH services. Services surrounding the fatality were not necessary due to the length of time since the fatality and services were offered at that time. Additional services were not required as the family identified SM no longer had any children in her care, nor visited with them.

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? No
Explain:
There was no service need identified for the SS after a discussion was held with their current caregiver, the MGM.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There was no service need identified for the MGM. The SM was less than cooperative in this investigation (10 years after the fatality) and no service needs were identified for her as well; furthermore, she had no children in her care at the time of this writing.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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? Yes

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

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)
05/05/2016	15195 - Other Child - SS's half sibling, Female, 7 Years	15222 - Other Adult - Step-father of SS; BF of other children in home, Male, 34 Years	Choking / Twisting / Shaking	Unfounded	No
	15195 - Other Child - SS's half sibling, Female, 7 Years	15222 - Other Adult - Step-father of SS; BF of other children in home, Male, 34 Years	Inadequate Guardianship	Unfounded	

Report Summary:
SCR report stated the allegedly maltreated child, age 7, was choked and punched by her BF. It was unknown if she sustained any injuries, or how often this occurred. The child's BF often called her derogatory names, and had a history of being physically assaultive to her as well as his other children (ages 13 and 10) and step-children (the SS, ages 15 and 14). The children's BM, their MGM, and the four children ages 10-15 were given unknown roles.

Determination: Unfounded | **Date of Determination:** 08/12/2016

Basis for Determination:
FCDSS interviewed family members (including private discussions with all children), contacted collaterals, and reviewed CPS history and found no evidence to substantiate the reported concerns. The allegedly maltreated child made no disclosure to the extent of what was reported and had no observable injury. FCDSS found the PS had provided harsh verbal directions to the 7 and 15-year-old female children, and was at times vocally harsh with the rest of the family, but no family members disclosed physical harm. The parents were directed to fix possible future safety concerns (a broken window and a hole in the floor) which the family partially completed prior to case closure.

OCFS Review Results:
FCDSS conducted an adequate investigation with respect to the allegations as well as addressed other concerns as they arose. FCDSS completed timely and accurate safety and risk assessments. FCDSS offered suggestions to the SS's mother when she expressed interest in having the SS evaluated for mental health.

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)
05/02/2016	15187 - Sibling, Female, 6 Years	15184 - Grandparent, Male, 46 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	15187 - Sibling, Female, 6 Years	15183 - Grandparent, Female, 48 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	15186 - Sibling, Male, 11 Years	15184 - Grandparent, Male, 46 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	15186 - Sibling, Male, 11 Years	15184 - Grandparent, Male, 46 Years	Inadequate Guardianship	Unfounded	
	15187 - Sibling, Female, 6 Years	15184 - Grandparent, Male, 46 Years	Inadequate Guardianship	Unfounded	
	15186 - Sibling, Male, 11 Years	15183 - Grandparent, Female, 48 Years	Inadequate Food / Clothing / Shelter	Unfounded	

15186 - Sibling, Male, 11 Years	15183 - Grandparent, Female, 48 Years	Inadequate Guardianship	Unfounded
15187 - Sibling, Female, 6 Years	15183 - Grandparent, Female, 48 Years	Inadequate Guardianship	Unfounded

Report Summary:
SCR report alleged MGM and MGF were caring for the two SS and resided in an apartment which was unsanitary and unsuitable for children. The report mentioned that the family had moved out of the unsanitary apartment one day prior to the report date.

Determination: Unfounded | **Date of Determination:** 06/27/2016

Basis for Determination:
MGM and MGF were caregivers for the children as the SM was reportedly not involved in their lives at this time. FCDSS made an unannounced visit, spoke with the family and collaterals, and made observations of the home. FCDSS determined there was insufficient credible evidence to substantiate the allegations in the report. The new apartment was found to meet minimal standards of care for the children, and it was concluded that even if the first apartment had been unsanitary, the caregivers had already mitigated the concern prior to CPS involvement.

OCFS Review Results:
FCDSS initiated the investigation promptly and adequately, making assessments of the children, their environment, and other potential child welfare concerns. There was one error on the RAP that could have affected the overall scoring. FCDSS documented successful and attempted efforts at speaking with absent biological parents as well as a check of CPS history.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
There was one error on the RAP that could have affected the overall scoring. CW indicated the children had not been in the care or custody of any substitute caregivers prior to report date, but commented about how the children were in the care of grandparents after previously being cared for by their biological parent(s). The comment was accurate, but the "Yes/No" response was not.

Legal Reference:
18 NYCRR 432.2(d)

Action:
FCDSS will complete all Risk Assessment Profiles with accuracy so to as to reflect the adequate level of risk within the family.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/25/2016	15644 - Other Child - Unrelated Child in Household, Male, 1 Years	15172 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated	Yes
	15644 - Other Child - Unrelated Child in Household, Male, 1 Years	15631 - Other Adult - Unrelated Adult, BF of Alleged Maltreated Child, Male, 21 Years	Inadequate Guardianship	Indicated	
	15644 - Other Child -	15172 - Mother, Female, 28 Years	Parents Drug	Indicated	

Unrelated Child in Household, Male, 1 Years		/ Alcohol Misuse	
15644 - Other Child - Unrelated Child in Household, Male, 1 Years	15621 - Other Adult - Unrelated Household Member, Male, 23 Years	Parents Drug / Alcohol Misuse	Indicated
15644 - Other Child - Unrelated Child in Household, Male, 1 Years	15621 - Other Adult - Unrelated Household Member, Male, 23 Years	Inadequate Guardianship	Indicated
15644 - Other Child - Unrelated Child in Household, Male, 1 Years	15622 - Other Adult - Unrelated Household Member, BM of Alleged Maltreated Child, Female, 22 Years	Inadequate Guardianship	Indicated

Report Summary:
SCR report alleged SM was involved in a physical altercation with two unrelated home members in the presence of one of the adult's one-year-old child. The child was knocked over by one of the adults and sustained a bump on his head. Additionally, the child was regularly left in SM's and the other adult's care during which time they smoked marijuana to impairment and exposed the child to the smoke. Allegations were later added against the child's BF when additional safety concerns arose.

Determination: Indicated | **Date of Determination:** 08/15/2016

Basis for Determination:
Although the altercation occurred, FCDSS learned a parent had the allegedly maltreated child (AMC) and other children in another room during the incident. The SM and other adult were kicked out of the home by residents. Though collaterals described SM and the other adult as "drug addicts" with "serious mental health concerns," FCDSS found no evidence that they had maltreated the children. FCDSS added allegations and IND the report against the AMC's BF, who had unstable housing and frequently relied on his 16 y/o girlfriend to care for the child. He failed to exercise a minimal degree of care when he deferred his responsibility to a minor whom he knew to be an irresponsible caregiver.

OCFS Review Results:
FCDSS made sufficient collateral and familial contacts. Caretaking risks were identified regarding the AMC's BM. BM requested Preventive Services but a decision was noted in the investigation that BM "had received services in the past without showing much improvement," and also "didn't appear to have the intellectual ability to gain more from additional long-term services at that time." No further suggestions were made when it was evident she could have benefited from some kind of service. Another physical altercation occurred in the AMC's presence where his BF could have been held responsible for placing the child at risk of harm, but this was not mentioned in the investigation conclusion.

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

Issue:
Failure to Offer Services

Summary:
The final RAP score was high. The AMC's BM also requested Preventive Services. Instead of deferring her to the Preventive Services intake process to be considered, a decision was noted that she "had received services in the past without showing much improvement," and also "didn't appear to have the intellectual ability to gain more from additional long-term services at that time."

Legal Reference:

SSL 424(10); NYCRR 428.6

Action:

When service needs are identified, FCDSS will make the appropriate referral to Preventive Services in an effort to determine whether there are services that can benefit the family.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day safety assessment was completed and approved two days late.

Legal Reference:

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

Action:

FCDSS will complete all safety assessments in the amount of time required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/27/2015	15200 - Sibling, Female, 14 Years	15196 - Other Adult - BM of SS, Female, 34 Years	Inadequate Guardianship	Unfounded	No
	15200 - Sibling, Female, 14 Years	15221 - Other Adult - Step-father of SS; BF of other children in home, Male, 33 Years	Inadequate Guardianship	Unfounded	

Report Summary:

SCR report alleged the 14-year-old SS had a hot cup of coffee thrown at her by her step-father after he had become angry with her. It was unknown if she sustained injuries as a result. The SS's BM was present and failed to intervene to protect the child. The step-father had a history of harming the children in the household, but the other children as well as the SS's MGM had unknown roles.

Determination: Unfounded **Date of Determination:** 07/21/2015

Basis for Determination:

FCDSS interviewed family members (including private discussions with all children), contacted collaterals, and reviewed CPS history and found no evidence to substantiate the reported concerns. The SS, her BM, and step-father all agreed a heated argument took place and provided consistent accounts of the events. The SS's BM slapped the SS's face once with an open hand and the step-father threw a small cup of cold coffee at the SS, both in response to the SS's irate actions and profanity when the parents were enforcing curfew. Neither action caused a mark, bruise or injury. FCDSS found the parents acted in a manner that was not appropriate, but did not place the SS at risk of substantial harm.

OCFS Review Results:

FCDSS conducted an adequate investigation with respect to the allegations and assessed for any other potential areas of concern. FCDSS completed timely and accurate safety and risk assessments.

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

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

11/18/2005-1/16/2006, SM & BF were IND for IG regarding 9-month-old SS.

3/6/2007-5/14/2007, SM & BF were alleged subjects (AS) on an UNF case for DOA/Fatality & IG regarding SC.

9/7/2007-1/7/2008, MGM was an AS on an UNF case for IG & LS regarding a 2 y/o SS.

4/14/2008-6/20/2008, SM was IND for IF/C/S & IG regarding a 3-day-old SS. SS was removed from SM's care at 2 months of age. BF was unable to be a sole caretaker. Preventive Services were opened. SM surrendered her rights in 2010 and the SS was adopted.

7/16/2008-12/31/2008 and 7/23/2012-9/30/2012, MGF was an AS on UNF cases regarding two SS. Allegations included IG & L/B/W.

5/30/2010-8/6/2010, SM & MGM were AS on an UNF case for PD/AM regarding 2 SS.

SM was an AS on 6 reports regarding children who were not her own. 5 were UNF; 1 was IND, but allegations against SM were Unsub. Report dates range from 2007-2013. Allegations included IG, IF/C/S, PD/AM, LS, and SA.

2 SS, who were BF's children with another mother, were confirmed maltreated children on 5 IND reports from 2004-2012. Confirmed allegations included IF/C/S, IG, L/B/W, & S/D/S. Indications were against their BM and step-father. Their MGM was also a confirmed subject on one of the reports. These SS were also listed on 15 UNF cases between 2006-2012, with subjects ranging from their BM, step-father, and other relatives. Unsub allegations included S/D/S, SA, C/T/S, EdN, LM, LS, XCP, IF/C/S, & IG.

Known CPS History Outside of NYS

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

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

6/23/2008-5/27/2010 Services were mandated following the removal of a 2-month-old SS. Concerns which warranted mandated services were: bed sharing with the SS (interpreted as high risk since SC's death was noted as a result of mother bed sharing with SC); SM's inability to adequately care for the medically fragile child; and, SM failing to seek timely, necessary medical care for the child. The SM and BF were referred to parenting classes and other health-focused services. Services were provided to the SS while he was in foster care. The BF passed away 8 months into the services case. The SM continuously showed minimal to no change with respect to the concerns being addressed by the services. The case was closed when the SM agreed to surrender her rights to the SS.

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

Action:	Given the unique circumstance that the SS were not listed on the report and had not been visited or cared for by SM in approximately two years, the Risk Assessment Profile (RAP) was inaccurately completed with SM as a primary caretaker. Nevertheless, the RAP was completed, and an elevated risk element question was answered incorrectly. FCDSS selected the response that SM had a previous Termination of Parental Rights (TPR), when SM had surrendered her rights to a child and not been terminated of parental rights. Due to these unique circumstances, OCFS is not requiring any action based on the error in the completed RAP; however, OCFS recommends FCDSS review training on completing all RAPs with accuracy.

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