Child Fatality Report

Report Identification Number: SY-20-057

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

Issue Date: Jun 04, 2021

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Tioga
Gender: Male
Date of Death: 12/14/2020
Initial Date OCFS Notified: 12/15/2020

Presenting Information

An SCR report was received which alleged that on the night of 12/14/20, the parent substitute violated an order of protection by having contact with the sixteen-year-old subject child. The parent substitute was aware of the child's history of using methamphetamines and also aware he was under the influence of the drug at that time. Despite knowing this, the parent substitute allowed the child to drive a car with her as the passenger. The child was driving at an excessive speed, and as a result, law enforcement attempted to pull the child over. Instead of complying, the child attempted to outrun the police and lost control of the car, causing a rollover crash. The child died instantly. The child's mother and father had unknown roles.

Executive Summary

This fatality report concerns the death of a sixteen-year-old male subject child that occurred on 12/14/20. On 12/15/20, Tioga County Department of Social Services (TCDSS) received the fatality report and investigated the child's death. An autopsy was completed, and the cause of death was noted as mechanical/positional asphyxia due to a rollover automobile collision. The child's toxicology was positive for THC, amphetamine, and methamphetamine.

At the time of the child's death, he was in the legal custody of his mother; however, chose not to live with her due to her substance abuse. The child would instead stay with various relatives and friends, including his stepmother, who was considered a parent substitute. The child's father was incarcerated when the fatality occurred and remained so at the time of this writing. The investigation revealed that on 12/15/20, the subject child and parent substitute had just left the mother's home in a borrowed vehicle. The child was driving, and the parent substitute was a passenger in the car. The parent substitute suspected the child had used drugs when he was inside his mother's home; however, allowed the child to drive the vehicle. The child began driving erratically, and eventually police attempted to pull the car over. The child refused to pull the vehicle over and began speeding to evade the police. The child lost control of the car and it landed on its roof over an embankment. The parent substitute was injured but able to call for an ambulance. The child was not wearing a seatbelt at the time of the accident. Emergency services arrived at the scene and found the child was already dead. The parent substitute was transported to the hospital for minor injuries.

From the time the investigation began to the time of its closure, TCDSS interviewed family members and collateral sources. Although no one reported witnessing the child engaging in substance use prior to the accident, his father and parent substitute reported he had a history of using drugs supplied to him by his mother. At the time of this writing, criminal charges were pending against the parent substitute for allowing the child to drive under the influence. TCDSS found evidence the mother and stepmother's actions or inaction placed the child at imminent risk of harm and therefore indicated and closed the case.

PIP Requirement

For issues identified in historical cases, TCDSS will submit a PIP to their Regional Office within 30 days of receipt of this report. The PIP will identify action(s) TCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, TCDSS 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
TCDSS gathered information to determine the allegations. There were no surviving siblings or other children in the household.

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 case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/14/2020 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 10:00 PM

County where fatality incident occurred: Tioga

Was 911 or local emergency number called? Yes

Time of Call: Unknown

Did EMS respond to the scene? Yes

At time of incident leading to death, had child used alcohol or drugs? Yes

Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **Passenger in vehicle.**

Total number of deaths at incident event:

Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	53 Year(s)
Other Household 1	Father	No Role	Male	39 Year(s)
Other Household 2	Stepmother	Alleged Perpetrator	Female	29 Year(s)

LDSS Response

On 12/15/20, TCDSS received the SCR report regarding the death of SC. TCDSS had been involved with the family since 9/13/20, after a FAR investigation was opened due to concerns PS left SC alone without electricity or food. Several subsequent SCR reports were received thereafter, with allegations PS was sexually abusing SC and SM was supplying SC with drugs. Upon receipt of the fatality report, TCDSS initiated their investigation within 24 hours and coordinated their efforts with their MDT. There were no surviving siblings or other CHN that resided with SC.

On 12/15/20, TCDSS spoke with BF via phone, as he was incarcerated. BF explained he was told SC and PS were at a relative's home when SC received a call that SM needed his help. SC took his aunt's car and drove to SM's home with PS as a passenger. BF stated SC went into SM's house for several minutes, and when he came out, he looked to be under the influence. BF said PS thought he may have smoked meth with SM. BF stated SC got back in the car and began driving erratically. BF reported when police attempted to pull SC over, he sped up trying to outrun them and lost control of the car. BF said SM was an addict and had a history of giving SC drugs. He denied any concerns regarding PS or her care of SC and had no further information about the fatality.

On 12/15/20, TCDSS spoke with EMS who responded to the accident. TCDSS was informed the car landed over an embankment and onto its roof. SC was not wearing a seatbelt and his head went through the windshield. EMS stated PS was injured, and SC was dead at the scene. EMS suspected PS was under the influence of drugs due to having "glassy eyes," but PS denied such.

On 12/24/20, TCDSS interviewed PS. PS explained that on the evening of 12/14/20, she and SC were visiting with family

at different locations after an aunt had allowed SC to borrow her car. PS said she accompanied him as a passenger, as she was worried about him driving alone in addition to his history of drug use. PS reported at some point, SC received a call from his MGM that SM needed help, so she rode with SC to SM's house. PS said when they arrived at SM's home, the help needed was giving MGM a ride to the store, so they brought her there and back. PS said SC went inside SM's for about 5 minutes to help bring in grocery bags while she waited in the car. They then left and shortly after, LE tried to pull SC over. PS stated rather than stop, SC accelerated and tried to get away from the police. She stated she yelled for him to stop numerous times and then they crashed. PS said she was injured, but able to call 911. She denied she used drugs and reported she had been sober for 2 years. PS stated she felt SC was under the influence of something during the incident because he refused to pull over for the police. PS had no other information surrounding the fatality, but expressed concern that SM had a history of giving drugs to SC. On a later date, LE informed TCDSS that PS's statement to police noted SC was acting like he was "on meth" when he got back into the car after leaving SM's house.

Throughout the investigation, TCDSS spoke with family members and collateral sources. LE had no record of an OP involving SC and PS. TCDSS discovered SC had been staying with relatives or at his girlfriend's house but did not solely reside with SM despite being in her custody. SM, her boyfriend, and MGM all denied supplying SC with drugs or alcohol at any time, but all were aware SC had a history of substance abuse. At the close of the investigation, LE had an endangering the welfare of a child charge pending against PS but were unable to move forward as PS had moved out of state. TCDSS found evidence that PS placed SC at imminent risk of harm by allowing him to drive when she felt he may have been under the influence, and therefore substantiated IG against PS. The allegations against SM were substantiated due to SM's ongoing drug abuse and her failure to provide adequate care of SC. TCDSS did not find evidence to show PS's actions or inaction caused SC's death, and there was no evidence gathered to support the allegation of SA. The investigation was indicated and closed.

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: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: This fatality investigation was conducted by the Tioga County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Tioga County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057122 - Deceased Child, Male, 16 Yrs	057126 - Stepmother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
057122 - Deceased Child, Male, 16 Yrs	057126 - Stepmother, Female, 29 Year(s)	Childs Drug / Alcohol Use	Unsubstantiated
057122 - Deceased Child, Male, 16 Yrs	057126 - Stepmother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
057122 - Deceased Child, Male, 16 Yrs	057126 - Stepmother, Female, 29 Year(s)	Sexual Abuse	Unsubstantiated

057122 - Deceased Child, Male, 16 Yrs	057123 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
057122 - Deceased Child, Male, 16 Yrs	057123 - Mother, Female, 38 Year(s)	Lack of Supervision	Substantiated
057122 - Deceased Child, Male, 16 Yrs	057123 - Mother, Female, 38 Year(s)	Parents Drug / Alcohol Misuse	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?	☒	☐	☐	☐
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:

TCDSS interviewed the family and collateral sources. Attempts were made to interview the parent substitute face to face; however she would only agree to a phone interview. BF was incarcerated during the investigation and only allowed to be interviewed via phone. Progress notes and other documentation were completed and entered within the required timeframes.

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

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

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Endangering the welfare of a child	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	PS	Pending	Pending
Comments:	Tioga County law enforcement had pending charges against the parent substitute for allowing the child to drive after suspecting he had been under the influence; however, she moved out of state before an arrest could be made.		

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:
Services were offered to the family in response to the death of the child, as well as to address ongoing concerns of drug use and mental health issues. There were no surviving siblings or other children in the household.

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? N/A

Explain:
There were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
TCDSS provided family members with resources for grief and bereavement services in their community.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
Were there any siblings ever placed outside of the home prior to this child's death? Yes
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/13/2020	Deceased Child, Male, 16 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 16 Years	Mother, Female, 38 Years	Lack of Supervision	Substantiated	
	Deceased Child, Male, 16 Years	Mother, Female, 38 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Male, 16 Years	Father, Male, 38 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 16 Years	Father, Male, 38 Years	Sexual Abuse	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepmother, Female, 28 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepmother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepmother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepmother, Female, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepmother, Female, 28 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepmother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

	Deceased Child, Male, 16 Years	Stepmother, Female, 28 Years	Sexual Abuse	Unsubstantiated

Report Summary:
This SCR report was received with concerns PS left home and failed to make an appropriate plan for SC. The report alleged SC was without food and electricity for an unknown period. Three subsequent reports were received with allegations PS was sexually abusing SC, failed to provide him with medical care, and PS and SM were providing SC with drugs.

Report Determination: Indicated | **Date of Determination:** 02/12/2021

Basis for Determination:
TCDSS completed interviews with PS and SC, who denied SA and denied not having access to basic needs. SC had an injury on his hand which he reported was from riding his dirt bike, and was observed to not be in need of medical attention. SC could not be located throughout much of the investigation, as he was staying with various friends and relatives. TCDSS worked diligently with LE to try and locate SC and were considering family court intervention prior to the fatality.

OCFS Review Results:
This investigation met all statutory requirements.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/23/2019	Deceased Child, Male, 14 Years	Mother, Female, 36 Years	Educational Neglect	Substantiated	Yes
	Deceased Child, Male, 14 Years	Father, Male, 36 Years	Educational Neglect	Unsubstantiated	

Report Summary:
This SCR report was received with concerns SC was not attending school and SM was failing to intervene. As a result, SC was failing his classes.

Report Determination: Indicated | **Date of Determination:** 03/23/2019

Basis for Determination:
TCDSS interviewed family and collateral sources including LE, the school, and PINS. Throughout the INV, SC ran away from home and was using drugs. Eventually, BF had a PINS warrant issued and SC was arrested. Electronic monitoring and substance abuse treatment was ordered; SC remained living with BF and on PINS. SC did not comply, and another warrant was issued. BF was arrested for contempt and incarcerated for unrelated matters. SM was using drugs and not an appropriate caretaker. SC's whereabouts remained unknown at the close of the case; however, he remained under the supervision of probation. Once located, SC was to be placed immediately in non-secure detention.

OCFS Review Results:
There were concerns of SM and her boyfriend engaging in drug use and leaving drug paraphernalia accessible in the home, which SC used to smoke with. The record did not reflect the then 17-year-old sibling residing in SM's home was interviewed about such, nor was she asked questions to assess overall safety and risk. The Seven Day Safety Assessment did not include any information surrounding the safety of the sibling.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
There were concerns of SM and her boyfriend engaging in drug use and leaving drug paraphernalia accessible in the home, which SC used to smoke with. The record did not reflect the 17yo sibling residing in SM's home was interviewed about such, nor was she asked questions to assess overall safety and risk.

Legal Reference:

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

Action:

Prior to making a determination, LDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The Seven Day Safety Assessment did not include any information surrounding the safety of the then 17-year-old sibling who resided in SM's home.

Legal Reference:

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

Action:

Within seven days of receiving a report, LDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/15/2019	Deceased Child, Male, 14 Years	Mother, Female, 36 Years	Educational Neglect	Substantiated	Yes
	Deceased Child, Male, 14 Years	Mother, Female, 36 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 14 Years	Mother, Female, 36 Years	Sexual Abuse	Substantiated	
	Other Child - Unrelated Child, Male, 5 Years	Other Adult - Unrelated Adult, Female, 36 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Other Child - Unrelated Child, Male, 5 Years	Other Adult - Unrelated Adult, Female, 36 Years	Inadequate Guardianship	Substantiated	
	Other Child - Unrelated Child, Male, 5 Years	Other Adult - Unrelated Adult, Female, 36 Years	Lack of Supervision	Substantiated	
	Deceased Child, Male, 14 Years	Other Adult - Unrelated Adult, Female, 36 Years	Educational Neglect	Unsubstantiated	
	Deceased Child, Male, 14 Years	Other Adult - Unrelated Adult, Female, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 14 Years	Other Adult - Unrelated Adult, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 14 Years	Other Adult - Unrelated Adult, Female, 36 Years	Sexual Abuse	Unsubstantiated	
	Other Child - Unrelated Child, Male, 5 Years	Other Adult - Unrelated Adult, Female, 36 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:

This SCR report was received with concerns SC was having a sexual relationship with an unrelated adult, who was considered a person legally responsible for SC. The report alleged SM was aware of the relationship and failed to intervene. There were further concerns regarding the unrelated adult and her 5yo child.

Report Determination: Indicated | **Date of Determination:** 03/09/2019

Basis for Determination:
TCDSS interviewed family members and collateral sources, including SC's school, LE, and service providers. It was determined the unrelated adult was not a person legally responsible for SC, and neither she nor SC disclosed a sexual relationship. TCDSS found despite SM's suspicions, she continued to allow SC to go to that person's home regularly. It was also discovered SC was not attending school, and SM often did not know where SC was. SC was considered a runaway at the close of this case and another remained opened and ongoing regarding SC to further address concerns.

OCFS Review Results:
The record did not reflect if the now adult sibling was interviewed or her safety assessed, as she was 17 years old at the time of this investigation.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
The now adult sibling was 17-years-old at the time of this report and living with SM. The record did not reflect that she was interviewed or if her safety was assessed, despite SM admitting to using methamphetamine. Further, she was not added to the case composition.

Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)

Action:
Prior to making a determination, LDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The Seven Day Safety Assessment did not include any information surrounding the safety of the then 17-year-old sibling who resided in SM's home.

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

Action:
Within seven days of receiving a report, LDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

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

From 2004 to 2017, SM was involved in six CPS investigations with common allegations of IG, PD/AM, L/B/W, B/S, and LS. Of those six investigations, three were indicated. There were three additional CPS investigations where SC and/or the now adult sibling were named as maltreated children with common allegations of IG and PD/AM. Of those investigations, one was indicated.

From 2012 to 2016, PS was in three CPS investigation with common allegations of IF/C/S, PD/AM, and IG. Of those investigations, PS was indicated in one.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

On 4/11/19, SC was placed in DSS custody via Juvenile Delinquency Order for one year due to obstruction of governmental authority after he attacked police and court officers. SC needed substance abuse treatment and was placed in a residential facility to address this as well as mental health and anger issues. SC was progressing with his treatment programs while the services case was open. The case was closed on 6/2/20 after the family moved out of county. SC was living with PS in that county and engaged in community-based services prior to case closure.

On 3/30/17, SM was involved in a voluntary PINS/Diversion services case regarding the now adult sibling, due to her ungovernable behaviors at home and at school, as well as ongoing drug use. The case was closed on 9/5/18 after the sibling successfully completed her treatment goals.

On 2/11/16, SC was involved in a voluntary preventive services case due to ungovernable behaviors at home, school and in the community. The case was closed on 9/12/16 after SC completed several months of therapy and his behaviors improved.

On 8/18/14, a voluntary PINS/Diversion services case was opened involving the now adult sibling and SM. This case was opened due to the sibling exhibiting ungovernable behaviors in school and at home. The case was closed on 12/24/14 per SM's request after the sibling's behaviors improved.

On 3/29/2008, a mandated preventive services case was opened due to SM and BF's involvement in illicit drug use and sale. The case was closed on 2/19/09 after all court-ordered stipulations were completed and there were no further safety concerns for the children.

Foster Care Placement History

In March of 2008, the family residence was raided by police and SM was arrested for endangering the welfare of a child after illicit drugs and evidence of drug sale were found. SM was also later arrested for driving while intoxicated, and BF was arrested for breaking into SM's home and not complying with an order of protection. SC and the now adult sibling were placed into foster care with a relative, but returned back to SM's care upon her completion of court stipulations in February of 2009.

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