Child Fatality Report

Report Identification Number: SY-17-015

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

Issue Date: Sep 12, 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	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Oneida
Gender: Female
Date of Death: 06/01/2013
Initial Date OCFS Notified: 04/28/2017

Presenting Information

An SCR report was received on 4/28/17 with allegations of PD/AM and IG against the SM regarding the SC and 4 SS. Additionally there was an allegation of DOA/Fatality against the SM regarding the SC and EdN regarding the 13-year-old SS. The report alleged that on 6/1/13 the SM was intoxicated and co-slept with the SC causing her death. The 4/28/17 report further alleged the SM consumed alcohol to the point of intoxication in the presence of the 4 SS and that the 13-year-old SS was failing school as a result of excessive absences. It was reported the SM was aware and did not intervene. This was a fatality previously reported and investigated by Oneida County Department of Social Services (OCDSS) at the time of the SC's death.

Executive Summary

This fatality report concerns the death of a 4-month-old female that occurred on 6/1/2013. The death of the SC was initially investigated by OCDSS at the time of the fatal incident. On 4/28/2017 an SCR report was again received by OCDSS regarding the death of the SC. The report alleged the SM was intoxicated, fell asleep on the couch with the SC and accidentally smothered the SC causing her death. The BF was sleeping in another room, unaware the SM was intoxicated. At about 7:30AM the SM found the SC unresponsive and took the SC to the BF to ask for help. The report alleged the BF was unable to help the SC as rigor mortis had already set in. The BF called 911. The 3 SS living at the time of the SC's death were not in the home at the time of the incident. There was no new information regarding the death of the SC provided in the 4/28/2017 report.

OCDSS began a new investigation into the death of the SC and the unrelated allegations upon receiving the 4/8/2017 SCR report. OCDSS contacted the source, the DA and appropriate collaterals. OCDSS interviewed the SM, BF, PS as well as the 4 SS to assess their safety. OCDSS pulled all information forward from the previous investigation.

There were 3 SS alive at the time of the SC's death. As a result of the fatality the SM consented to the removal of these children. The SS were placed in the care of the PGM through kinship foster care, under the supervision of OCDSS. During this time period, the SM and BF also resided in the home of the PGM. OCDSS filed abuse petitions against the SM and BF. The Family Court ordered the SM and BF to have supervised contact with the SS and to abstain from alcohol or drug use. The abuse petition against the BF was later dismissed and he was awarded custody of the SS. The SM made an admission to neglect and was under the supervision of the court for a period of 1 year. During that time the SM participated in MH and Substance abuse treatment. The SM had since re-married and had another child with the PS. The BF moved out of New York State and the SM was awarded custody of the 3 SS. There were no concerns for any of the SS in the care of the SM and PS during the investigation.

OCDSS contacted the DA regarding the fatality. The DA reported the SM was criminally charged with endangering the welfare of a child as a result of the fatality and was placed under the supervision of probation. The DA did not find it necessary to involve LE again in the death of the SC, as the matter was already investigated.

The ME determined the cause of death for the SC was unexplained sudden death infancy associated with co-sleeping and the manner of death was undetermined.

At the time of this report the CPS Investigation had not been determined and remained open. The previous fatality

investigation in 2013 led OCDSS to substantiate allegations of PD/AM and IG against the SM for the 3 SS and the SC. There was no new evidence presented in the recent investigation that would lead OCDSS to a different determination regarding the fatality.

For the citation that follows, OCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. This PIP will identify what action OCDSS has taken, or will take, to address the cited issue. For citations where a PIP is currently implemented, OCDSS will review the plan 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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

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 fatality was investigated previously at the time of death and OCDSS worked with the family at that time. The family has no current need for services from OCDSS.

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

Child Fatality Report

Date of Death: 06/01/2013 **Time of Death:** Unknown

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

County where fatality incident occurred: Oneida
Was 911 or local emergency number called? Yes
Time of Call: 07:01 AM
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? No - but needed
At time of incident supervisor was:

- ☐ Drug Impaired
- ☒ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	4 Month(s)
Deceased Child's Household	Father	No Role	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	9 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Year(s)

LDSS Response

OCDSS received an SCR report on 4/28/17 regarding the death of the SC. OCDSS contacted the source, DA, ME and reviewed CPS history, including the historical fatality investigation. OCDSS interviewed the 3 SS that were alive at the time of the SC's death, the SF and the SM regarding the SCR report. After learning the SM had remarried and had another child, OCDSS saw the child and assessed his safety. The SM's husband was also interviewed regarding the allegations of the SCR report. Each person interviewed denied any current alcohol use by the SM or her husband. OCDSS made regular home visits and always found the to be appropriate. OCDSS contacted the schools of the SS and family members as part of the investigation. There were no concerns for the safety and well-being of any of the children.

The fatality of the SC was investigated by LE and OCDSS jointly in 2013 when the death occurred. OCDSS contacted the DA as part of the re-reported fatality investigation and the DA said criminal charges were pursued against the SM at the time of the fatality and no further LE involvement was necessary.

OCDSS learned the 3 SS were initially removed from the SM with her consent and placed in the care of the PGM and PGF for a brief period in 2013 when the SC died. The BF was granted custody of the SS in July 2013. OCDSS filed abuse petitions against the SM and SF in 2013. The SM made an admission of neglect, and was under the supervision of the family court for 1-year and during this time participated in court ordered services, while having supervised visits with the children. The petition against the SF was dismissed in January 2014. The SM had since regained custody of the 3 SS and the SF moved out of the state with his wife and had minimal contact with the children.

OCDSS did not find any new information about the fatality in their interviews or review of the evidence and records of the previous investigation. At approximately 7:00AM on 6/1/13, the SM woke to find the SC laying next to her, cold and unresponsive. She went to get the SF who was sleeping in their bedroom. The SF called 911 and emergency personnel responded to the home. The SC was determined to be deceased at the home. The SM and SF had been out alone the evening before the fatality. The 3 SS were at the PGM's home and the PGF was caring for the SC at his home until the SM and SF picked her up at about 9:30PM. The SC was sleeping when they picked her up at the PGF's home and when they arrived home they put her to sleep in her pack and play in their bedroom. The SM went to the living room and watched television on the couch and the SF went into the bedroom to sleep. At about 11:30PM the SC woke and the SF brought her to the SM in the living room. The SM fed and burped the SC and put her in an infant seat and the SC fell back asleep. The SM reported that around 2:00 or 3:00AM, she fed the SC again and then laid down with her on the couch. The SM and SC were both positioned on their sides, facing one another. The SM stated she put a blanket around herself and the baby. The SM admitted that she and the SF took one drink together prior to the SC waking up, however she denied she was intoxicated at all. The morning the SC was found, the SM was questioned by police, and provided a breathalyzer test at around 10:00AM. The breathalyzer registered a blood alcohol content of .07, just under the legal limit regarding driving a vehicle.

OCDSS learned both parents were aware of safe sleep practices. The SM reported she often slept on the couch with the SC.

The ME completed an autopsy of the SC. The preliminary autopsy report showed the SC was a well-developed and nourished infant. There was no evidence of traumatic injury or disease to account for the death, and there was no evidence the SC had died from asphyxiation. The final cause of death was Sudden Unexplained Death in infancy associated with co-sleeping on the couch. The manner of death was undetermined.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a 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 original fatality investigation was conducted in 2013, at the time of the SC's death. There was a joint investigation between LDSS and LE at that time.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
038984 - Sibling, Male, 9 Year(s)	038982 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
038984 - Sibling, Male, 9 Year(s)	038982 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Pending
038984 - Sibling, Male, 9 Year(s)	038982 - Mother, Female, 33 Year(s)	Educational Neglect	Pending
038985 - Sibling, Male, 8 Year(s)	038982 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Pending
038985 - Sibling, Male, 8 Year(s)	038982 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
038986 - Sibling, Female, 6 Year(s)	038982 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
038986 - Sibling, Female, 6 Year(s)	038982 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Pending
039928 - Sibling, Male, 2 Year(s)	038982 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
039928 - Sibling, Male, 2 Year(s)	038982 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Pending
039929 - Deceased Child, Female, 4 Month(s)	038982 - Mother, Female, 33 Year(s)	DOA / Fatality	Pending
039929 - Deceased Child, Female, 4 Month(s)	038982 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
039929 - Deceased Child, Female, 4 Month(s)	038982 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Pending

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?	☒	☐	☐	☐

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	☒	☐	☐	☐
Explain: The risk assessment was not complete at the time of this report.				

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?

☒Family Court ☒Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/06/2013	Adjudicated Neglected	Order of Supervision
Respondent:	038982 Mother Female 33 Year(s)	
Comments:	On 6/3/13 OCDSS removed the three SS with consent of the SM. The children were placed with the paternal grandparents as a certified kinship foster home. On 6/6/13 OCDSS filed an abuse petition against the SM and BF. Also, the paternal grandparents were given direct custody of the three SS. On 7/29/13 the BF received custody of the SS. On 1/15/14 there was a fact finding and the SM made an admission to neglect. There was a 1-year order of supervision put in place.	

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Subject Mother	Unknown	guilty
Comments:	The SM was sentenced to 1 year probation as a result of her conviction.		

Have any Orders of Protection been issued? Yes	
From: 07/29/2013	**To:** 01/29/2014
Explain: An Order of Protection was put in place against the SM regarding all three SS. There was to be no unsupervised contact with the children and she was to refrain from using alcohol before or while seeing the SS.	
From: 06/06/2013	**To:** 07/29/2013
Explain: An Order of Protection was put in place against the SM and BF regarding the three SS. They were ordered to refrain from using drugs/alcohol while in the presence of the children and could have no unsupervised contact with the children.	

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	☐	☐	☐	☐	☐	☒	☐

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:
These services were previously provided after the SC's death in 2013.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
These services were previously provided after the SC's death in 2013.

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? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

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)
12/02/2014	Sibling, Female, 7 Years	Other - Parent Substitute (PS), Female, 37 Years	Other	Unfounded	No
	Sibling, Male, 10 Years	Mother, Female, 35 Years	Other	Unfounded	
	Sibling, Female, 7 Years	Mother, Female, 35 Years	Other	Unfounded	
	Sibling, Male, 10 Years	Other - Parent Substitute (PS), Female, 37 Years	Other	Unfounded	
	Sibling, Male, 9 Years	Other - Parent Substitute (PS), Female, 37 Years	Other	Unfounded	
	Sibling, Female, 7 Years	Other - Parent Substitute (PS), Female, 37 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 9 Years	Mother, Female, 35 Years	Other	Unfounded	

Report Summary:
On 12/1/14, the PS forcibly dragged the 7-year-old SS by the hair from the home into the garage. This caused the SS a lot of pain, but the SS had no visible injuries. The incident occurred because the SS forgot to put a hat away. The BF intervened at some point and stopped the PS. The roles of the BF and other three SS were unknown.

A duplicate SCR report and Court Ordered Investigation were merged with this investigation.

Determination: Unfounded | **Date of Determination:** 01/23/2015

Basis for Determination:
All the children in the home were interviewed and had differing stories regarding the event reported. The PS admitted the SS forgot to pick up her hat and she put her hand on the back of the SS neck and guided her to the garage to pick it up.

The PS suggested her nails may have accidentally caught the SS hair. There was no credible evidence that the PS physically disciplined the children. The SM and BF were going through a custody dispute in family court and both filed violations against each other during this period. An Order of Protection was in place forbidding the PS to use corporal punishment and there was no information found that she was not following the order.

OCFS Review Results:
OCDSS interviewed all subjects and children listed on the report. OCDSS also interviewed all the children in the home. All appropriate notices were sent. Risk and Safety Assessments were completed timely. OCDSS made collateral contacts as needed to gather more information. There was ongoing court and DSS involvement at the close of the case.

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)
09/18/2014	Sibling, Female, 7 Years	Grandparent, Female, 54 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 7 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 7 Years	Grandparent, Female, 54 Years	Sexual Abuse	Unfounded	

Report Summary:
The MGM had been inappropriately touching the vaginal area of a SS for her own gratification. The BM was aware and did not intervene.

Determination: Unfounded **Date of Determination:** 11/25/2014

Basis for Determination:
OCDSS interviewed the SS and the other children in the home, in addition to the BF, PS, SM, and MGM. The source of the report denied ever reporting the SS was sexually abused by the MGM. The SS denied ever being touched inappropriately by anyone. The MGM and SS explained the SS experienced burning and pain when she urinated, and the MGM applied Vaseline to soothe the inflammation. The BF took the child to the doctor and medicine was prescribed. There was no disclosure or evidence of any sexual abuse. The MGM no longer examined the SS and applied ointments.

OCFS Review Results:
OCDSS made appropriate contact with everyone named in the report. Collateral contacts were made with the school, but not the doctor for the children. The safety and risk assessments were completed accurately and on time. As issues arose in the investigation, OCDSS promptly addressed the concerns with the BF, SM and PS.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
OCDSS noted the BF signed HIPPA release forms, but there is no documentation in the case record to indicate collaterals were contacted. The allegations specifically concerned a physical ailment suffered by the SS. OCDSS documented the BF reported taking the child for medical care and as a result a topical medication was prescribed for the child. There is no documentation the doctor was contacted.

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

Action:
OCDSS will document in the case record contact made with collateral contacts, when the contact is believed to have relevant information to the investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/08/2014	Sibling, Male, 10 Years	Other - Parent Substitute (PS), Female, 36 Years	Other	Unfounded	No
	Sibling, Male, 9 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 7 Years	Mother, Female, 35 Years	Other	Unfounded	
	Sibling, Female, 7 Years	Father, Male, 33 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 9 Years	Father, Male, 33 Years	Other	Unfounded	
	Sibling, Male, 9 Years	Other - Parent Substitute (PS), Female, 36 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 7 Years	Other - Parent Substitute (PS), Female, 36 Years	Other	Unfounded	
	Sibling, Male, 10 Years	Father, Male, 33 Years	Other	Unfounded	
	Sibling, Female, 7 Years	Father, Male, 33 Years	Other	Unfounded	
	Sibling, Male, 10 Years	Other - Parent Substitute (PS), Female, 36 Years	Excessive Corporal Punishment	Unfounded	
	Sibling, Male, 9 Years	Father, Male, 33 Years	Lack of Medical Care	Unfounded	
	Sibling, Male, 9 Years	Mother, Female, 35 Years	Other	Unfounded	
	Sibling, Female, 7 Years	Other - Parent Substitute (PS), Female, 36 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 10 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 10 Years	Mother, Female, 35 Years	Other	Unfounded	
	Sibling, Male, 10 Years	Father, Male, 33 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 9 Years	Other - Parent Substitute (PS), Female, 36 Years	Excessive Corporal Punishment	Unfounded	
	Sibling, Male, 9 Years	Father, Male, 33 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 10 Years	Other - Parent Substitute (PS), Female, 36 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 9 Years	Other - Parent Substitute (PS), Female, 36 Years	Other	Unfounded	
	Sibling, Female, 7 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 7	Other - Parent Substitute (PS),	Excessive Corporal	Unfounded	

Years	Female, 36 Years	Punishment	
Sibling, Male, 10 Years	Father, Male, 33 Years	Lack of Medical Care	Unfounded
Sibling, Male, 10 Years	Other - Parent Substitute (PS), Female, 36 Years	Lacerations / Bruises / Welts	Unfounded

Report Summary:
Parent substitute (PS) hit SS in the face and on their elbows with a bamboo stick. PS was using excessive force as a form of punishment. PS grabbed SS by the arm and left finger print bruises. BF failed to protect the children from PS. Two of the SS had contact with either poison ivy or poison oak and developed a severe rash to the face, ears and arms. BF failed to seek any medical care for the children and the rash worsened with bleeding blisters developing. Recently PS forced a SS to sleep on the kitchen floor because he had accidentally wet the bed. BF violated a court order by moving in with PS. The SM has an unknown role.

There were 2 additional subsequent reports merged.

Determination: Unfounded | **Date of Determination:** 07/28/2014

Basis for Determination:
OCDSS interviewed the PS, BF and SM as well as the children. After speaking with everyone listed on the case as well as appropriate collateral contacts, OCDSS determined there was no credible evidence to substantiate any of the allegations. The SS did report that they were "smacked" by the PS, but never had marks. The SS denied they were fearful of the PS or BF. The SS had visits with the SM and lived with the BF and PS along with her 4 children. The BF explained allergies caused the rashes on the SS, and provided proof of medical treatment. The BF and SM's divorce was final at the case closing and the SS were healthy. There was no credible evidence to substantiate the allegations.

OCFS Review Results:
OCDSS checked CONNECTIONS history at the onset of the investigation. OCDSS interviewed all necessary casework contacts and made several unannounced home visits, and documented the contacts with detail. OCDSS spoke with school staff, medical professionals, family members, law enforcement and MH providers to gather information. The safety and risk assessments were completed accurately and timely. OCDSS diligently worked with both parents during the investigation and addressed issues as they arose during the investigation. OCDSS made an appropriate determination for all allegations and all casework activities were well documented.

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

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

3/25/2013-5/17/2013- An SCR report with allegations of IG and PD/AM SUB against the SM regarding the SC and SS and allegation of OTHER (Court Ordered Investigation)was UNSUB against the SM and BF regarding the SC and SS. An additional allegation of C/T/S was also UNSUB against the SM regarding the SC.

6/1/2013-1/15/2014-An SCR report with allegations of IG and PD/AM IND against SM and BF for the SS and against the SM for the SC. Additionally an allegation of DOA/Fatality was UNSUB against the SM and SF regarding the SC.

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

The SS were in the custody of the paternal grandparents from 6/6/13 until 7/29/13, when the BF was granted custody. The mandated preventive case was initiated on 6/03/13 and concluded on 2/10/15. The case was opened as a result of the death of the SC. The SM demonstrated in inability to stop using alcohol and was supervised with the children. The BF was not found responsible for the death of the SC and he successfully completed a substance abuse evaluation and services. OCDSS continued to monitor the children in the care of the BF and monitored the SM's participation in treatment and services. The Family Court ordered the SM to 1-year of supervision beginning 1/15/14. The preventive case commenced when the SM had successfully completed all services and there was no longer court ordered supervision.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: An Order of Protection was put in place against the SM that she would not use alcohol. This was issued by Family Court after she was arrested, because she was found to be intoxicated while the sole caretaker for the children.	

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