Child Fatality Report

Report Identification Number: SY-17-055

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

Issue Date: May 24, 2018

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

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

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

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

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

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 12/18/2017
Initial Date OCFS Notified: 12/22/2017

Presenting Information

An SCR report alleged that on 12/16/17 at about 7:30PM, SF was home with the 1-month-old SC while SM, MGM and MGF were shopping. SF was holding SC and stood up to make a bottle. His foot got caught on a blanket and he tripped and fell with the SC, landing on top of him. SC began gasping for breath and SF began CPR. SF called and spoke to MGM, who told SF to wait until they returned home, which was 20 minutes later. When they returned, SM and the grandparents found SC to be limp and his cry was "different." MGM eventually called 911. SC sustained blood in all 4 quadrants of his brain, significant retinal bleeding, and bruising along his left ribs. SC died 2 days later on 12/18/17. The injuries sustained were inconsistent with the explanation provided, which made the injuries suspicious in nature. In addition, there was a delay in medical care. All 4 adults were primary caregivers for the SC and were all named as alleged subjects.

Executive Summary

On 12/21/17, Oneida County Department of Social Services (OCDSS) received a CPS report concerning the death of the SC. It was noted SC was declared brain dead on 12/18/17 at 4:03PM after having sustained life-threatening injuries 2 days prior. OCDSS had already been investigating the fatal incident in CPS reports dated 12/17/17 and 12/18/17, which contained similar descriptions of events and circumstances.

OCDSS interviewed family members, as well as first responders who spoke with SF immediately following the incident. SF reported on 12/16/17 at approximately 7:30PM, he fell with SC in his arms when his foot got caught on a blanket. After the fall, he observed SC to be limp and listless, and he began CPR. He then called SM to tell her what happened and ask for help. SM was with MGM and MGF at the store, and they immediately left to come home. When all adults were home, it was determined SC needed emergency medical care and 911 was called at 8:07PM. SC presented at the hospital with brain bleeding in the subarachnoid and intraventricular areas, as well as bilateral retinal hemorrhaging. SC had a low rate of breathing and low body temperature.

At the time this report was written, the autopsy report had not been completed, though the preliminary report revealed rib fractures under the areas of bruising on SC's chest. A skull fracture was initially suspected but ruled out. OCDSS gathered a copious amount of information from medical professionals and LE, conducting a multi-disciplinary investigation into the death. The Pediatric Trauma Medical Doctor provided a detailed statement about the injuries, noting neurosurgical intervention was not performed as the brain injury was catastrophic and not survivable. The clinical findings were noted as highly concerning for non-accidental trauma, in addition to there being a significant delay in seeking medical care. The statement noted the rarity of severe brain injuries from short falls, and clarified that subdural hemorrhaging (bleeding within areas of the brain) is strongly associated with abusive head trauma. It was concluded, "…the findings of retinal hemorrhaging, severe brain injury, and rib fractures with the absence of other injuries such as fracture, soft tissue swelling or bruising to the head are consistent with abusive head trauma, likely involving shaking injury. The injuries cannot be plausibly explained by a history of a short fall and represent substantial evidence of inflicted injury."

When LE interviewed SF, he admitted the fall with SC did not occur exactly how he had previously told LE and EMS. SF mentioned SC was fussy, and said he was shaking while holding SC due to his high anxiety, prior to the fall. LE was awaiting the final autopsy report before transferring the case to the District Attorney's office. Presently, no criminal charges have been filed.

OCDSS assessed the safety of the only surviving sibling (SS), age 5. OCDSS spoke with SS's MGM (legal custodian) who noted SF had not seen SC since the summer, when OCDSS had filed a Neglect Petition against him and he was ordered to have supervised contact only. The petition had stemmed from incidents of excessive corporal punishment. SS's MGM cited instances of SF being physical with SS as an infant, and shared she would protect SS by not allowing SF contact with SS during the investigation. When interviewed, SS said he had never met SC. OCDSS learned an adult not named in the report was living in the home at the time of the fatality (SM's cousin) though she was reportedly not in the home at the time of the fatal incident. OCDSS saw her at a home visit and did not interview her at that time, and later attempts to make casework contact were unsuccessful. SCDSS offered grief counseling and assistance with burial services. The adults utilized their own counseling, and SS continued to receive his regular MH Tx.

The CPS investigation remains open, and all allegations are pending determination.

PIP Requirement
OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issue. If a PIP is currently implemented, OCDSS will review the plan and revise as needed to address any ongoing 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?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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?** N/A

Explain:
Though the interventions were appropriate to protect the SS, the incorrect Safety Decision was recorded on the Initial Safety Assessment (noted placement was required, though no child was placed). OCDSS continued to gather information about the fatality to make an informed decision about the allegations; the investigation had not been determined at the time of the writing of this fatality report.

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

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 investigation remained open at the time this report was written, and the allegations had yet to be determined. All casework activity was commensurate with case circumstances and there were detailed notes of supervisory consultation.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	All Safety Assessments inaccurately documented a Safety Decision #4, that removal to or continuation in Foster Care or an Alternative Placement Setting was necessary, though SS was never once removed into Foster Care or Alternative Placement Setting.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each safety assessment must be accurately documented in the case record in order to reflect case circumstances with regard to safety.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/18/2017 **Time of Death:** 04:03 PM

Date of fatal incident, if different than date of death: 12/16/2017
Time of fatal incident, if different than time of death: 07:30 PM

County where fatality incident occurred: Oneida
Was 911 or local emergency number called? Yes
Time of Call: 08:07 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	62 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	46 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Other Adult - SM's Cousin	No Role	Female	30 Year(s)
Other Household 1	Sibling	No Role	Male	5 Year(s)

LDSS Response

OCDSS continued their investigation into the circumstances which led to the death of SC upon receiving the SCR report on 12/21/17. OCDSS had begun investigating on 12/17/17 in response to an SCR report alleging abuse of the SC by his father (SF). There were also 3 subsequent reports made between 12/17/18 and 12/18/17. Much of the information in all 5 reports were similar, with some variations in presenting symptoms, and some noted a SS who was currently a protected party in an OP against SF. The reports consistently noted SF's explanation did not match the nature of SC's extensive injuries; additionally, there was an approximate 40-minute delay in medical care. SC met brain death criteria in a second test on 12/18/17, at which point he was declared deceased; however, a fatality report could not be registered until SC was taken off life support. This occurred on 12/21/17 for purposes of organ donation.

OCDSS completed thorough casework activities, commensurate with case circumstances. Within 24 hours of both reports (12/17/17 and 12/21/17), OCDSS documented the 5yo SS was protected by his MGM with whom he lived and of whom he was under the regular care. He was interviewed at his home and revealed no information with relevancy to the fatality, as he had never met SC nor witnessed SF interact with him.

Due to the location of the hospital, Onondaga County CPS was assigned a secondary role and observed SC in the hospital prior to his death, as well as interviewed SF and SM. After the death, OCDSS re-interviewed SF and observed a separate interview conducted by LE. OCDSS learned the timeline of events leading up to the fatality from SF, as he was the only person home at the time of the fatal incident (SM, MGM and MGF were out shopping, and noted SC was fine prior to their leaving). SF initially reported he was holding SC in his bed when SC appeared hungry, so he got up to get a bottle, but his leg got caught in a blanket. SF said he lost his balance and fell forward onto SC who was still cradled in his arms; as a result, SC's head hit between SF's arm and chest, but not the floor. He noticed SC had difficulty breathing and appeared listless, so he started chest compressions and breathed into his mouth. SF then called SM for help. MGM gave SF instructions over the phone as to ways to attempt to rouse SC while they drove home. When home, the adults assessed SC and decided to call 911. EMS arrived approximately 1 hour after the incident due to the delay in time the caregivers called 911. SF later changed his account with LE, stating he'd had high anxiety prior to the fall and was shaking while holding SC. SF then asked for a lawyer. SF denied any and all drug or alcohol use, prior to the fatal incident or otherwise. SM and the maternal grandparents denied having concerns for SF caring for SC, and reported not believing he hurt the child, though they were aware of SF's recent history of using excessive corporal punishment on SS which led to court-ordered supervised visits.

OCDSS made multiple home visits and completed timely safety assessments. OCDSS assessed the living environments of SC and SS, and spoke with all relevant familial and collateral contacts. OCDSS kept contemporaneous and detailed documentation and noted frequent supervisory consultation. OCDSS offered appropriate services to the family. OCDSS

documented continued efforts to make face-to-face contact with the family at the time of the writing of this report, and the case remained open.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: This fatality has not yet been reviewed by the Oneida County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045581 - Deceased Child, Male, 1 Mons	045585 - Grandparent, Male, 62 Year(s)	Inadequate Guardianship	Pending
045581 - Deceased Child, Male, 1 Mons	045582 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
045581 - Deceased Child, Male, 1 Mons	045583 - Father, Male, 26 Year(s)	DOA / Fatality	Pending
045581 - Deceased Child, Male, 1 Mons	045582 - Mother, Female, 26 Year(s)	Lack of Medical Care	Pending
045581 - Deceased Child, Male, 1 Mons	045583 - Father, Male, 26 Year(s)	Internal Injuries	Pending
045581 - Deceased Child, Male, 1 Mons	045583 - Father, Male, 26 Year(s)	Lacerations / Bruises / Welts	Pending
045581 - Deceased Child, Male, 1 Mons	045583 - Father, Male, 26 Year(s)	Lack of Medical Care	Pending
045581 - Deceased Child, Male, 1 Mons	045583 - Father, Male, 26 Year(s)	Inadequate Guardianship	Pending
045581 - Deceased Child, Male, 1 Mons	045584 - Grandparent, Female, 46 Year(s)	Inadequate Guardianship	Pending
045581 - Deceased Child, Male, 1 Mons	045585 - Grandparent, Male, 62 Year(s)	Lack of Medical Care	Pending
045581 - Deceased Child, Male, 1 Mons	045584 - Grandparent, Female, 46 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐

Explain:
Though completed on time, 3 Safety Assessments inaccurately documented a Safety Decision #4, that removal to or continuation in Foster Care or an Alternative Placement Setting was necessary to protect the SS. The assessments mentioned SS and noted SF was court-ordered to only have supervised contact with the SS. OCDSS reiterated no unsupervised contact as a safety plan. In his lifetime, SS was never removed into Foster Care or any Alternative Placement Setting.

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 Profile had not been completed at the time of the writing 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?	☐	☒	☐	☐
Explain as necessary: No removal was necessary regarding the SS.				

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	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	☐	☐	☐	☒	☐	☐	☐

Other, specify: Anger Management

Additional information, if necessary:
The adult family members stated they all attend counseling but denied it was grief counseling. They reported they plan to set up grief counseling at a future date. Burial assistance was offered and the family noted they had already begun the process. Anger management should have been offered to SF due to the concerns, as he never completed it as recommended just prior to this report.

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:
The SS continued to receive MH counseling as he had prior to the SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SM, SF, MGM and MGF reportedly received counseling in response to the fatality.

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

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)
12/17/2017	Deceased Child, Male, 1 Months	Mother, Female, 26 Years	Fractures	Pending	No
	Deceased Child, Male, 1 Months	Father, Male, 26 Years	Inadequate Guardianship	Pending	
	Deceased Child, Male, 1 Months	Father, Male, 26 Years	Internal Injuries	Pending	
	Deceased Child, Male, 1 Months	Mother, Female, 26 Years	Inadequate Guardianship	Pending	
	Deceased Child, Male, 1 Months	Mother, Female, 26 Years	Lacerations / Bruises / Welts	Pending	
	Deceased Child, Male, 1 Months	Father, Male, 26 Years	Choking / Twisting / Shaking	Pending	
	Deceased Child, Male, 1 Months	Mother, Female, 26 Years	Internal Injuries	Pending	
	Deceased Child, Male, 1 Months	Mother, Female, 26 Years	Lack of Medical Care	Pending	
	Deceased Child, Male, 1 Months	Father, Male, 26 Years	Fractures	Pending	
	Deceased Child, Male, 1 Months	Father, Male, 26 Years	Lacerations / Bruises / Welts	Pending	
	Deceased Child, Male, 1 Months	Father, Male, 26 Years	Lack of Medical Care	Pending	

Report Summary:
SCR report alleged on 12/16/17, SF fell on top of SC. SC was lethargic; SF delayed medical Tx. SC had bruising to his face, ribs, & bottom of his feet. SC had brain bleeding in all lobes at the subarachnoid level; it was unknown if SC would survive. The explanation did not match the injuries. It was unknown who inflicted the injuries; SM & SF were both named subjects. Three subsequent reports were made on 12/17 & 12/18 with similar information, additionally alleging a

skull fracture & injuries indicating severe shaking. One report stated SF said SC's head never hit the floor during the fall. Two reports noted SF had a 5yo CH (SS), for whom there was an active OP to refrain from XCP.

Determination: Undetermined

OCFS Review Results:
OCDSS conducted this investigation concurrently with the fatality investigation which came in on 12/21/17 after the SC was taken off life support. OCDSS documented all casework activity simultaneously in both reports. Similar to the fatality investigation, OCDSS inaccurately documented a Safety Decision #4 in the 7-day safety assessment, though no child was ever removed and placed in Foster Care or an Alternative Placement Setting as a result of the safety concerns. This citation is noted above in review of the fatality investigation.

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)
05/24/2017	Sibling, Male, 5 Years	Father, Male, 25 Years	Inadequate Guardianship	Indicated	No
	Sibling, Male, 5 Years	Father, Male, 25 Years	Lacerations / Bruises / Welts	Indicated	
	Sibling, Male, 5 Years	Father, Male, 25 Years	Excessive Corporal Punishment	Indicated	

Report Summary:
SCR report alleged while SS was visiting SF and his parent substitute (SM), SF became frustrated with SS for waking him up and put his hands over SS's mouth and nose to the point SS could not breathe. A subsequent report on 7/8/17 alleged SF had a history of being physically aggressive toward SS, for which he has sustained bruises as a result. Sometime in the week prior, SF became out of control toward SS and for disciplinary reasons, hit SS multiple times resulting in several bruises along his back and buttocks. Roles of the parent substitute (SM) and SS's MGM were unknown for both reports.

Determination: Indicated **Date of Determination:** 07/26/2017

Basis for Determination:
OCDSS observed bruising, redness, and a hand imprint on SS's buttocks. LE obtained statements and SF admitted he spanked SS's bare buttocks 6-10 times. SS's MGM acted appropriately by calling police and taking SS to the hospital. SS also told CW about the time SF covered SS's mouth at the time of the first report. SF had denied it and SCDSS discussed physical discipline; SS was deemed credible following the second incident (initially there was no information to corroborate SS's account). SF was arrested for Endangering the Welfare of a Child. OCDSS filed a Neglect Petition against SF on 7/17/17 and eventually SF agreed to work with CPS services.

OCFS Review Results:
OCDSS interviewed all family members face-to-face (except for the BF of SS's MGM's CHN, though efforts were made). OCDSS contacted all necessary collaterals. OCDSS appropriately responded to concerns as they arose, and sufficiently communicated concerns to the SF. OCDSS fittingly filed a Neglect Petition to compel services for the family's benefit. OCDSS diligently attempted to contact the BF of other CHN named in the report.

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)
03/22/2017	Sibling, Male, 5 Years	Other Adult - PS (SS's MGM's Boyfriend), Male, 53 Years	Sexual Abuse	Unfounded	Yes
	Sibling, Male, 5 Years	Other Adult - SS's MGM, Female, 42 Years	Sexual Abuse	Unfounded	

Sibling, Male, 5 Years	Other Adult - PS (SS's MGM's Boyfriend), Male, 53 Years	Excessive Corporal Punishment	Unfounded
Sibling, Male, 5 Years	Other Adult - SS's BM, Female, 21 Years	Other	Unfounded
Sibling, Male, 5 Years	Other Adult - SS's BM, Female, 21 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 5 Years	Other Adult - SS's MGM, Female, 42 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 5 Years	Other Adult - SS's MGM, Female, 42 Years	Other	Unfounded
Sibling, Male, 5 Years	Father, Male, 25 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 5 Years	Father, Male, 25 Years	Other	Unfounded

Report Summary:
SCR report alleged SS was sexually abused by his PS (SS's MGM's boyfriend) and his MGM and father (SF) were aware, failed to intervene, and continued to allow the PS access to SS. PS has also spanked SS as a form of discipline, leaving bruises on SS's lower back. The roles of SS's BM and 4 other CHN, ages 17, 10, 7, and 1, were unknown. A subsequent report on 4/5/17 was a court-ordered investigation regarding the report in relation to custody and visitation matters.

Determination: Unfounded | **Date of Determination:** 06/06/2017

Basis for Determination:
The investigation was jointly conducted with LE and SS was forensically interviewed, revealing no disclosure of SA or physical discipline. The other verbal CHN in the home (SS's MGM's children) were interviewed and denied SA or physical discipline as well. The adults in the home denied the allegations and reported PS was never even alone with the CHN, except for his granddaughter (age 1). The family felt SF made the report to gain custody of SS; the SF had alleged the SS was disclosing the SA to him. The court-ordered investigation was submitted and there were no changes made to custody or visitation for SS; SS's MGM maintained physical custody with joint custody to SF and SS's BM.

OCFS Review Results:
OCDSS appropriately addressed the report with a multidisciplinary approach and addressed the allegations within 24 hours. OCDSS completed a thorough investigation into the report and any other possible areas of concern. OCDSS conducted face-to-face interviews with all family members and attempted such with the BF of SS's MGM's CHN. OCDSS also searched for information on PS's grandchild's BF. OCDSS promptly and appropriately responded each time new concerns arose during the investigation.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
More than 15 progress notes were entered more than 2 months after the event dates.

Legal Reference:
18 NYCRR 428.5

Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded, as required by regulation.

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
No secondary caretaker was identified on the RAP despite SF's regular caretaking role of SS and the fact that he was a subject of the report.
Legal Reference:
18 NYCRR 432.2(d)
Action:
OCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/12/2015	Sibling, Male, 3 Years	Other Adult - SS's BM, Female, 20 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Male, 3 Years	Other Adult - SS's BM, Female, 20 Years	Other	Indicated	
	Sibling, Male, 3 Years	Other Adult - SS's MGM, Female, 40 Years	Other	Indicated	

Report Summary:
SCR report alleged SS's BM was granted custody of him on 5/26/15, and on 9/8/15, she brought him to his MGM's home and left him there. SM stated she did not want him, could not control him, could not deal with him, and wanted to punch him in the face. SS did not feel his mother loved or cared about him, and was afraid of her. A subsequent report on 9/15/17 concerned a court-ordered investigation (COI) regarding the custody of the SS.

Determination: Indicated | **Date of Determination:** 11/18/2015

Basis for Determination:
OCDSS learned in interviewing SS's BM that she had no bond with him and could not care for him. CW observed the SS with his BM and noted the BM acted aloof toward SS's needs. His BM also did not have stable housing. OCDSS noted no concerns for the SS with his MGM. BM eventually made arrangements for both her CHN to live with relatives while she obtained a suitable and stable residence. SS's MGM was awarded custody on or about 9/28/15.

OCFS Review Results:
OCDSS assessed the safety of all CHN named in the report and addressed concerns as that arose from family members. OCDSS visited each home where each child resided and/or visited, except for the BM's house as she was reportedly homeless and then uncooperative with visits to her temporary homes.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
More than 15 progress notes were entered 1-2 months after the event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded, as required by regulation.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:

The RAP inaccurately noted the SS was never previously in the care of an alternate caregiver, despite OCDSS' knowledge SS was previously in the care of his MGM.

Legal Reference:

18 NYCRR 432.2(d)

Action:

OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/19/2015	Sibling, Male, 3 Years	Other Adult - SS's BM, Female, 19 Years	Other	Unfounded	No
	Sibling, Male, 3 Years	Other Adult - SS's MGM, Female, 40 Years	Other	Unfounded	
	Sibling, Male, 3 Years	Father, Male, 23 Years	Other	Unfounded	

Report Summary:

SCR report initiated as a result of a court-ordered investigation concerning SS (then age 3) and his caregivers (SF, his BM, and his MGM). SS's BM filed for custody of SS, who had previously been in the custody of his MGM.

Determination: Unfounded | **Date of Determination:** 07/22/2015

Basis for Determination:

OCDSS submitted the court-ordered investigation and identified risk factors but no immediate safety concerns for the SS with his BM or MGM. Court resulted in custody being awarded to his BM, and SS moved back into her home. OCDSS found BM's home met minimal standards.

OCFS Review Results:

OCDSS assessed the safety of all CHN named in the report. OCDSS completed a thorough investigation of the report and any other possible areas of concern. OCDSS was unable to make contact with SF, who reportedly did not visit with the SS.

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)
07/23/2014	Sibling, Male, 2 Years	Other Adult - SS's MGM, Female, 39 Years	Lacerations / Bruises / Welts	Unfounded	Yes
	Other Child - SS's MU (SS's MGM's CH), Male, 4 Years	Other Adult - PS (SS'S MGM's Boyfriend), Male, 43 Years	Inadequate Guardianship	Unfounded	
	Other Child - SS's MU (SS's MGM's CH), Male, 4 Years	Other Adult - SS's MGM, Female, 39 Years	Excessive Corporal Punishment	Unfounded	
	Other Child - SS's MU (SS's MGM's CH), Male, 4 Years	Other Adult - SS's MGM, Female, 39 Years	Lacerations / Bruises / Welts	Unfounded	

Other Child - SS's MA (SS's MGM's CH), Female, 6 Years	Other Adult - PS (SS'S MGM's Boyfriend), Male, 43 Years	Inadequate Guardianship	Unfounded
Other Child - SS's MU (SS's MGM's CH), Male, 4 Years	Other Adult - PS (SS'S MGM's Boyfriend), Male, 43 Years	Lacerations / Bruises / Welts	Unfounded
Other Child - SS's MA (SS's MGM's CH), Female, 6 Years	Other Adult - SS's MGM, Female, 39 Years	Excessive Corporal Punishment	Unfounded
Other Child - SS's MA (SS's MGM's CH), Female, 6 Years	Other Adult - SS's MGM, Female, 39 Years	Inadequate Guardianship	Unfounded
Other Child - SS's MA (SS's MGM's CH), Female, 6 Years	Other Adult - SS's MGM, Female, 39 Years	Lacerations / Bruises / Welts	Unfounded
Other Child - SS's MU (SS's MGM's CH), Male, 4 Years	Other Adult - SS's MGM, Female, 39 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 2 Years	Other Adult - SS's MGM, Female, 39 Years	Excessive Corporal Punishment	Unfounded
Sibling, Male, 2 Years	Other Adult - SS's MGM, Female, 39 Years	Inadequate Guardianship	Unfounded
Other Child - SS's MA (SS's MGM's CH), Female, 6 Years	Other Adult - PS (SS'S MGM's Boyfriend), Male, 43 Years	Excessive Corporal Punishment	Unfounded
Other Child - SS's MA (SS's MGM's CH), Female, 6 Years	Other Adult - PS (SS'S MGM's Boyfriend), Male, 43 Years	Lacerations / Bruises / Welts	Unfounded
Other Child - SS's MU (SS's MGM's CH), Male, 4 Years	Other Adult - PS (SS'S MGM's Boyfriend), Male, 43 Years	Excessive Corporal Punishment	Unfounded
Sibling, Male, 2 Years	Other Adult - PS (SS'S MGM's Boyfriend), Male, 43 Years	Excessive Corporal Punishment	Unfounded
Sibling, Male, 2 Years	Other Adult - PS (SS'S MGM's Boyfriend), Male, 43 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 2 Years	Other Adult - PS (SS'S MGM's Boyfriend), Male, 43 Years	Lacerations / Bruises / Welts	Unfounded

Report Summary:
SCR report alleged SS's MGM routinely called her own children (ages 6 and 4) as well as SS (age 2) derogatory names. It further alleged the MGM's live-in boyfriend (a PS) punched SS's MGM with force about her body and threatened to kill her while in the presence of the 3 CHN. Also, the year prior, the PS kicked the 4yo CH in the head with force when the CH flushed a toy down the toilet. A subsequent report was made later the same day, alleging both adults used physical discipline on the CHN, both called them degrading names, and the CHN have had marks and bruises as a result of discipline. PS also drank alcohol to excess and abused illicit and prescription drugs.

Determination: Unfounded | **Date of Determination:** 09/15/2014

Basis for Determination:
OCDSS interviewed the 2 verbal CHN and 2 subjects, and all denied the allegations. The CHN denied witnessing DV or being hit or called names as punishment. OCDSS observed the CHN to be free from apparently inflicted marks and/or bruises. A DV referral was made but SS's MGM did not respond to the advocate's attempts at contact. During home visits, including unannounced visits, the adults appeared sober. At the end of the investigation the MGM and PS stopped dating; he left the home, and had no further contact with the CHN. Upon thorough investigation into the allegations and any other potential concerns, OCDSS found no safety concerns for the CHN.

OCFS Review Results:
OCDSS conducted a thorough investigation into the alleged concerns as well as any other areas of potential concern. OCDSS contacted relevant collaterals and interviewed the CHN on more than one occasion. OCDSS documented detailed observations and casework. OCDSS made diligent efforts to contact 3 absent parents.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP did not identify a secondary caretaker, despite 2 subjects being named on the report.

Legal Reference:
18 NYCRR 432.2(d)

Action:
OCDSS will accurately reflect all caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

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

There was only 1 CPS investigation that involved persons named in the fatality report more than 3 years prior to the fatality. In a report dated 6/13/13, SS, then age 1, was a confirmed maltreated CH. The confirmed subjects were SS's BM and his PS. Non-confirmed subjects included SF, SS's MGM, and the father of SS's aunt and uncle (who were also children). Confirmed allegations were IF/C/S and IG; unsubstantiated allegations included OTH/COI and L/B/W.

Known CPS History Outside of NYS

There was no documented CPS history for any of the family members outside of New York State.

Preventive Services History

On 7/19/17, a mandated CPS Services case was opened for SF, SS, and SS's MGM (who had physical custody of SS). The case was opened following an indicated CPS report against SF, with concerns that SF was using excessive physical discipline on the 5yo SS. SF had been arrested for Endangering the Welfare of a Child based on this, and OCDSS had filed a Neglect Petition against SF in an effort to compel services. OCDSS drug tested SF (finding no need to refer for substance abuse treatment), kept in contact with SF's MH provider, and a parent aide was provided to assist SF with parenting skills and learn appropriate discipline techniques. When the case closed on 10/6/17, SF had engaged in MH services and attended all appointments, as well as all sessions with the parent aide. He was reportedly waiting to get into an anger management class where he attended MH counseling, SF obtained joint custody of SS (MGM maintained primary physical custody) and SF continued to have supervised visitation with SS per the Court issued OP, though his visits were not

regular and consistent. SS's MGM ensured SS attended his own MH counseling. Upon closing the case, OCDSS provided SF information on community-based services, as well as information on safe sleep due to knowledge SF and his wife were expecting a child (SC).

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/17/2017	There was not a fact finding	Order of Supervision
Respondent:	045583 Father Male 26 Year(s)	
Comments:	OCDSS filed a Neglect Petition against SF following incidents of excessive corporal punishment against his son (SS). SF had been charged with Endangering the Welfare of a Child on or about 7/13/17 regarding the incident where he spanked SS in excess, leaving marks and bruises. SF made an admission of neglect. Services were court-ordered for SF to complete, such as parenting skills and anger management. OCDSS was tasked with supervising and monitoring the services. An order of protection was also issued, permitting only supervised contact between SF and SS and barring the use of corporal punishment.	

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/19/2015	There was not a fact finding	CustodyGuardianship assigned to relative or non-relative (Article 6 non-foster care)
Respondent:	None	
Comments:	SS's MGM had physical custody of the SS from the time he was an infant to assist his young BM with his care. SS's BM filed for custody back on or about 5/19/15, and after a court-ordered investigation, BM was awarded custody on 5/26/15. Less than 4 months later she left him in the care of his MGM, stating she was unable to care for him. Additionally, she had unstable housing. MGM was again awarded physical custody of the SS on or about 9/28/15. MGM has maintained custody over the years, with SS's parents having joint custody.	

Criminal Charge: Endangering the welfare of a child	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	SF	Unknown	Unknown
Comments:	In July 2017, SF was arrested for Endangering the Welfare of a Child regarding his 5yo son (SS). SF admittedly spanked SS on his bare buttocks in excess of 6-10 times leaving marks and bruises. SS also alleged approximately 2 months prior that SF used his hand to cover SS's mouth to the point he could not breathe when SF became upset with him. An OP was issued such that SF not use corporal punishment on SS.		

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: On or about 7/19/17, an order of protection was issued for SS against SF. SF was not to use corporal punishment, and all contact was to be supervised. This was following a criminal arrest for Endangering the Welfare of a Child and Family Court action.	

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