Child Fatality Report

Report Identification Number: SY-17-044

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

Issue Date: Dec 20, 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	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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 09/09/2017
Initial Date OCFS Notified: 09/10/2017

Presenting Information

An SCR report was received alleging that the SC passed away on 9/9/17 for unknown causes while in the care of the SM. There was no explanation for the SC's death.

Executive Summary

This report concerns the death of the 4-year-old male SC. On 9/9/17 Onondaga County Department of Social Services (OCDSS) received an SCR report regarding the fatality. The report alleged the SC was laid down for a nap and later found by the SM to be unresponsive. The report further alleged the SC died of unknown causes and without an explanation while in the SM's care.

An autopsy of the SC was performed by the ME. The ME provided OCDSS with a preliminary autopsy report. The ME reported the SC had a complex medical history and external and internal examinations showed no evidence of injury. The toxicology report showed the SC had high lethal levels of lorazepam, fentanyl and heroin in his system. The ME believed the SC orally ingested the drugs because there was plastic found in the SC's mouth and he was known to ingest things. The ME also advised OCDSS that the SC was on prescribed medication, but no medication was located at the SC's home. The ME suggested that the SM was non-compliant with the SC's medical care.

OCDSS reviewed the SC's medical records. The pediatrician reported that the SC had missed several neurology appointments in the last year and it was unknown when he was last seen. The SM reported to the doctor that the neurologist refilled the SC's medications although it was unclear when he was last seen by their office. The medical records also documented the SM's report that the SC had been out of most of his medications as of April of 2017, and the SM failed to contact the neurologist to request medication refills. The SM also stated the SC had 2 mild seizures in February and March of 2017. Also, in April of 2017, the pediatrician noted the SC had not received recommended physical or occupational therapy services in 3 months. The SM told the pediatrician this was because the SC was on a wait list within the school district for those services.

LE walked through of the home and interviewed the adults present on the day of the fatal incident. LE shared information with OCDSS. LE searched the home of the SM and the home of OA1 after receiving the SC's toxicology results. The OA1 admitted to using heroin at the SC's home the day of his death, and LE found heroin in OA1's home. LE continued their investigation at the time this report was written.

OCDSS notified and interviewed all three biological fathers of the SC and SS. OCDSS also spoke with the PA of a SS and the MGM of the CHN as they had provided care to the SS before and after the death of the SC. OCDSS also contacted the schools attended by the SS. OCDSS spoke with all first responders and received a copy of the 911 call. OCDSS did not speak with the SM's friend (OA1) that was babysitting the SC at the time of his death. LE shared their interviews of OA1 with OCDSS, but OA1 should have been added to the case composition of the CPS investigation. This would have enabled OCDSS to notify her and interview her regarding the events leading up to the fatality. OCDSS could have gathered more information by also contacting the neurologist and pharmacy that provided the SC's medication. These collateral contacts may have provided information regarding the SM's compliance with medical recommendations for the SC.

OCDSS had not yet made a determination at the time of this writing and there was more information needed to make a

determination. The SM had arranged for the 3 SS to live with other relatives, and at the time this report the SS remained with the relatives. OCDSS was contemplating filing a neglect petition against the SM. OCDSS offered bereavement services to the SM, SS, MGM and PA during the investigation. OCDSS also assisted the MGM in enrolling the 5yo SS in school and arranging for transportation. The SM and SS were offered preventive services, burial assistance, bereavement counseling and clothing assistance.

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?** 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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The CPS Investigation remained open at the time this report was written.

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 CPS Investigation remained open at the time this report was written.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	The caretaker for the SC and last person to see the SC alive was not listed on the report received from the SCR, and never added to the report by OCDSS. At a minimum, OA1 should have been added as a another person named and interviewed by OCDSS.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	OCDSS will add individuals to SCR reports as needed, based on the facts discovered during a CPS investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/09/2017 **Time of Death:** 08:00 PM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 07:02 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? No - but needed
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	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	13 Year(s)
Other Household 1	Grandparent	No Role	Female	55 Year(s)
Other Household 2	Father	No Role	Male	34 Year(s)
Other Household 3	Other Adult - SS BF	No Role	Male	41 Year(s)
Other Household 4	Other Adult - SS BF	No Role	Male	32 Year(s)
Other Household 5	Other Adult - SS PA	No Role	Female	22 Year(s)

LDSS Response

OCDSS began an investigation into the death of the SC on 9/9/17 after receiving an SCR report. OCDSS contacted LE, the

DA, first responders, hospital staff and the ME. The SC had several medical issues and received occupational and physical therapy during the previous school year. The SC was under the care of a neurologist and prescribed several medications at the time of his death, including anti-seizure medication.

The SC had four SS (ages 18,13, 9 and 5). OCDSS saw the 9yo and 5yo CHN at the home of the MGM. The CHN were assessed to be safe and the MGM reported the CHN would stay with her while the SM grieved the loss of the SC. The 13yo SS was seen at the home of his PA; he was also assessed to be safe. The 13yo SS was staying with his PA the month preceding the SC's death. The 18yo SS was away at college at the time of the SC's death, and remained there after the fatality.

OCDSS interviewed the SM at her home. The SM said her friend (OA1) arrived at her home around noon the day of the fatal event. The SM left around 3:00PM that day to go grocery shopping, leaving the SC, 9yo and 5yo SS with OA1. The SM could not say what time she returned home. SM returned and found the 5yo SS was locked out of the home. The 9yo SS unlocked the door into the home. The SM did not know why the 5yo SS was locked out of the home and deferred to OA1 for an explanation. The SM asked OA1 where the SC was and OA1 said she had laid him down for a nap. The SM reported she began preparing dinner. The SM went to the bathroom upstairs and while walking by the bedroom she saw the SC lying asleep on the floor. The SM said it was normal for the SC to fall asleep on the floor. Coming back from the bathroom SM went into the bedroom and realized the SC was not breathing. The SM tried to wake the SC and call 911, but reported her phone was not working. The SM then yelled out and carried the SC downstairs and outside to the front porch. The SM said a neighbor called 911. The SM said there was a small piece of plastic on the SC's tongue, but denied there was anything stuck in his throat that could have obstructed his breathing. The SM reported the SC liked to play with plastic bags. The SM told OCDSS she saw white foam coming from his mouth. The SM denied any alcohol or drug use.

LE shared their interview and statement from OA1 with OCDSS. OA1 arrived at the home of the SC at noon the day of the fatality. OA1 said at 3:00PM the SM went to the grocery store and OA1 babysat the 3 CHN. The OA1 said the SC was upstairs with her while she cleaned the bathroom and at 4:00PM she laid him down for a nap in the bedroom. OA1 said she checked on the SC at 4:15PM and 4:30PM and he lifted his head and laid back down both times. At 5:00PM the SM returned home with groceries and they began preparing dinner. OA1 heard the SM yelling upstairs and found the SM holding the SC and crying. OA1 said the SC was cold and she called 911. OCDSS did not interview OA1.

OCDSS interviewed the 9yo and 5yo SS regarding the day of the fatality. The 9yo SS said that the day of the SC's death OA1 was caring for the 5yo SS, SC and himself while the SM was at the store. The 9yo and 5yo denied that the 5yo was ever locked out of the home on that day. The 9yo SS said they watched television while SM was out. The SS did not provide any other details regarding the day of the fatality.

OCDSS spoke with LE and learned LE found some plastic on the floor where the SC slept. LE also corroborated it appeared as dinner was being prepared at the time of the incident and the upstairs bathroom appeared to have been recently cleaned.

EMS reported the SC was on the front porch when they arrived and they took over CPR from LE. EMS did not recall seeing other CHN other than the SC.

OCDSS contacted the BF of the SS and 5yo SS, as well as the BF of the 9yo and 13yo SS. The BF of the SC was concerned about the SM’s care of the 5yo SS given the death of the SC.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

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
041993 - Deceased Child, Male, 4 Yrs	041994 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
041993 - Deceased Child, Male, 4 Yrs	041994 - Mother, Female, 33 Year(s)	DOA / Fatality	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	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

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

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☒	☐	☐	☐	☐	☐	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☒	☐	☐	☐	☐	☐	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☒	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/07/2017	Sibling, Male, 13 Years	Mother, Female, 33 Years	Burns / Scalding	Unfounded	No
	Sibling, Male, 13 Years	Mother, Female, 33 Years	Educational Neglect	Unfounded	

Sibling, Male, 13 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unfounded

Report Summary:
An SCR report was received with allegations of a 12yo SS missing an excessive amount of school, causing him to fail as a result. The SS also had a burn on the inside of his thigh and the explanation was inconsistent with the injury.

Determination: Unfounded | **Date of Determination:** 09/27/2017

Basis for Determination:
The SS sustained the burn from falling on a table top grill that was hot. The SS failed to report the injury to the SM until days after this happened. The SS had excessive absences from school and received poor grades, but was promoted to the next grade level at the end of the school year. The absences had no negative impact. The SM met with the school officials and an agreement was reached to prevent excessive absences in the future.

OCFS Review Results:
The source was contacted and notices of the SCR report sent to absent parents. All safety assessments and the risk assessment were completed. During the course of the investigation, the SC and SS went to stay with family out of state. Several attempts were made to see all the CHN. At the case determination, all CHN were seen except the SC, but he passed away shortly after returning to New York State.

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)
03/31/2017	Sibling, Male, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	No

Report Summary:
An SCR report was received alleging the SM left a 5yo SS alone for 30 minutes and he was not mature enough to be left alone. The report was determined to be FAR eligible and the family agreed to FAR as well. The SM denied ever leaving the SS home alone and reported herself or the then 12yo SS were home. The 5yo SS said once he came home and neither the SM or SS were there. A plan was made with the bus driver to ensure the 5yo child was not allowed off the bus unless a caregiver was home. The issue presented was resolved and the case closed.

OCFS Review Results:
The SM was seen and interviewed and a home visit done. The SS were interviewed and the source contacted. The FLAG, safety and Risk Assessments were completed and notes entered in a timely manner. The issue presented in the report was discussed and a plan was put in place to prevent the child being left alone in the future.

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)
09/16/2016	Sibling, Male, 9 Years	Mother, Female, 33 Years	Educational Neglect	Indicated	No
	Sibling, Male, 9 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 13 Years	Mother, Female, 33 Years	Educational Neglect	Indicated	
	Sibling, Male, 13 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 13 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated	

Sibling, Male, 9 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated
Deceased Child, Male, 4 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 4 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated
Sibling, Male, 5 Years	Mother, Female, 33 Years	Educational Neglect	Indicated
Sibling, Male, 5 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated
Sibling, Male, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated

Report Summary:
An SCR report was received alleging the SM left the 3 SS and SC home alone for hours at a time and sometimes overnight. The SC had severe disabilities and was unable to walk or talk and the eldest SS was not mature enough to watch the other children. A subsequent SCR report was made on 9/27/17 and consolidated. The report alleged the eldest SS had excessive absences from school and is not doing well academically as a result.

Determination: Indicated | **Date of Determination:** 12/01/2016

Basis for Determination:
Through several unannounced home visits, the SS and SC were found to be cared for appropriately by the SM. There was a single time that the SS and SC were found home without an adult, but the eldest SS seemed mature and able to competently look after his siblings. The SS missed a considerable amount of school, impacting their education. OCDSS found evidence that the SM was failing to meet the minimum standard of care by failing to be sure the SS went to school regularly. OCDSS offered services, but the SM moved out of the county before the investigation was closed.

OCFS Review Results:
The SM was interviewed and several home visits were made. The SS were seen and interviewed and collaterals contacts, including the source, were made. Notice of existence letters were sent to the absent BF. The SM was offered ongoing services to assist her in providing for the basic needs of the children, but declined because she moved out of the district. OCDSS contacted the county where the family moved and requested a visit be done to see the SM, SS and SC in the new home. OCDSS learned the children were enrolled in school in the new district.

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)
10/26/2015	Deceased Child, Male, 4 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	No
	Deceased Child, Male, 4 Years	Mother, Female, 33 Years	Lack of Medical Care	Far-Closed	

Report Summary:
An SCR report was received with concerns that the SC was developmentally delayed, had an illness and the SM failed to comply with treatment recommendations. As a result the SC was hospitalized.

OCFS Review Results:
FAR was discussed with the SM at the initial home visit and explained in detail. The BFs were notified and the FLAG was completed with the SM. OCDSS spoke with service providers working with the SM and SC who reported the SM attended to the SC's needs.

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

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

An SCR report was received on 5/22/14 with allegations of IG Unsub against the SM regarding the SC and 2 SS.

An SCR report was received on 4/24/13 with allegations of IG Unsub against the SM regarding the SC and youngest SS. The allegation of IG was Sub against the BF of the SC and SS, regarding these children.

An SCR report was received on 12/19/11 with allegations of IG and L/B/W Unsub against the SM regarding the eldest SS.

An SCR report was received on 6/23/11 with allegations of IF/C/S, IG, L/B/W and PD/AM Unsub against the SM regarding 2 SS.

An SCR report was received on 2/18/11 with allegations of EdN and IG against the SM regarding the eldest SS. The case was tracked to FAR and closed.

An SCR report was received on 6/11/99 with an allegation of IG Sub against the SM regarding a SS.

Known CPS History Outside of NYS

There is no known history outside of New York State.

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? 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