

Report Identification Number: SY-18-017

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

Issue Date: Sep 04, 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 <u>only</u> 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			
DrDoctor	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	ACS-Administration for Children's	NYPD-New York City Police			
Service	Services	Department			
PPRS-Purchased Preventive	TANF-Temporary Assistance to Needy	FC-Foster Care			
Rehabilitative Services	Families				
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 Jurisdiction: Cortland Date of Death: 04/19/2018

Age: 2 year(s) Gender: Female Initial Date OCFS Notified: 04/20/2018

Presenting Information

An SCR report was received on 4/20/18, alleging that on 4/19/18 at about 8:00PM, the 2-year-old SC was left unsupervised. The SC was in the care of the PS during this time. The SC reportedly climbed up on a bunk bed and fell onto the floor. As a result of the fall, the SC had bruises on her arms, legs, stomach, right temple and a hematoma on the left side of her head. The SC died as a result of her injuries.

There were two subsequent SCR reports received regarding the fatality. The subsequent reports alleged the PS was drinking alcohol at the time of the incident and delayed in getting the SC medical attention. It was also alleged the PS gave the SC medication to make her sleep after she fell off the bed. The mother was named as a subject in one of the subsequent reports, because it was unknown who or what caused the injuries to the SC.

Executive Summary

This report concerns the death of the 2-year-old female SC. Cortland County Department of Social Services (CCDSS) received 3 SCR reports regarding the fatality on 4/20/18. The SC had been alone with the PS the evening of 4/19/18, while the SM was at work. The SC reportedly fell off the top of a bunk bed and was injured. The PS called 911 after the SC's condition worsened. First responders found the SC with bruising all over her body and a skull fracture. There were concerns the explanation provided was not plausible given the SC's injuries. Although the SM was not home at the time the SC was injured, there was a concern she was aware of the multiple bruises and did not intervene to protect the SC. The SC was an otherwise healthy child. It was unclear what occurred the evening of 4/19/18 to cause the SC's demise, but the explanation provided by the PS was not plausible given her extensive injuries and evidence found in the home.

An autopsy was performed by the ME. The manner of death was declared as homicide and the cause of death blunt head trauma. The ME believed the SC's injuries were the result of a one time assault and found no signs of chronic abuse. The SC had over 50 contusions and abrasions about her body and also suffered internal hemorrhaging.

LE did not pursue criminal charges against the SM. LE determined the SM had no knowledge of the abuse that the PS perpetrated against the SC. LE concluded the SM asked appropriate questions of the PS when the PS reported the SC was injured, and he was dishonest in his answers. The PS was charged with murder in the 2nd degree, manslaughter in the 1st degree, criminally negligent homicide and endangering the welfare of a child. LE continued to investigate the fatal incident at the time this report was written and were awaiting DNA results from evidence gathered.

CCDSS made extensive efforts to assess the safety of the SS and also the PS's two children. CCDSS filed a neglect petition against the PS regarding the SS, on the basis of derivative neglect. CCDSS worked with a neighboring county to assess the safety of the PS's children. The BM of the PS's children was urged to take action to protect her children, in the event the PS is released from incarceration. CCDSS made contacts with several of the PS's family, as well as the SM's family. CCDSS was thorough in gathering information throughout the investigation. The SS and the PS's children were deemed to be safe.

CCDSS appropriately substantiated the allegations of IG, LS, PD/AM, L/B/W, S/D/S, II and DOA/Fatality against the PS regarding the SC. There was no explanation for the SC's injuries and ultimate death, while in the care of the PS and medical professionals deemed the death non-accidental. The PS admitted to drinking alcohol on the evening of 4/19/18, while he was the sole caretaker for the SC. The allegations of IG and L/B/W against the SM were unsubstantiated. There



was no credible evidence the SM had any knowledge the PS would abuse the SC and the injuries the SC sustained were the result of a single incident. The allegation of IG against the PS and SM regarding the SS were appropriately unsubstantiated as the SS were not in the home at the time of the incident.

CCDSS offered numerous supportive services to the SM, including parenting classes, mental health, burial assistance, grief counseling, victim support services and Preventive Services. The SM accepted all services offered. CCDSS offered grief counseling services to the SS and these services were declined.

PIP Requirement

CCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) CCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDSS will review the plan and revise as needed to address ongoing concerns.

	Findings Related to the CPS Investigation of the	ne 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
Deterr	mination:	
•	Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?	Yes, sufficient information was gathered to determine all allegations.
•	Was the determination made by the district to unfound or indicate appropriate?	Yes
Was tl	he decision to close the case appropriate?	Yes
	asework activity commensurate with appropriate and relevant statutory ulatory requirements?	Yes
Was tl	here sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.
Expla	in:	
The ca	sework was commensurate with the case circumstances.	

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Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? Yes



Fatality-Related Information and Investigative Activities

Incident Information					
Date of Death: 04/19/2018 Time of Death: Unknown					
Time of fatal incident, if differ	ent than time of death:		Unknown		
County where fatality incident	t occurred:		Cortland		
Was 911 or local emergency no	umber called?		Yes		
Time of Call:			Unknown		
Did EMS respond to the scene	Yes				
At time of incident leading to o	No				
Child's activity at time of incid	lent:				
☐ Sleeping	☐ Working	☐ Drivin	g / Vehicle occupant		
☐ Playing	Eating	⊠ Unkno	own		
Other					
Did child have supervision at t	ime of incident leading to	death? Yes			
Is the caretaker listed in the H	ousehold Composition? Y	es - Caregiver 2			
At time of incident supervisor	was:				
Drug Impaired		Absent			
Alcohol Impaired		Asleep			
Distracted		☐ Impaired by illness			
☐ Impaired by disability		Other:			
Total number of deaths at inci	dent event:				
Children ages 0-18: 1					
Adults: 0					

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Other Adult - Parent Substitute	Alleged Perpetrator	Male	29 Year(s)
Other Household 1	Other Adult - BF of 4yo SS	No Role	Male	26 Year(s)
Other Household 1	Sibling	Alleged Victim	Female	4 Year(s)
Other Household 2	Other Adult - BF of 8yo SS	No Role	Male	31 Year(s)
Other Household 2	Sibling	Alleged Victim	Male	8 Year(s)
Other Household 3	Father	No Role	Male	34 Year(s)

LDSS Response	



CCDSS began their investigation on 4/20/18, after receiving 3 SCR reports. CCDSS did a CPS history search, contacted the sources, first responders and coordinated their investigation with LE. LE told CCDSS the DA had been notified. CCDSS contacted the BF of the SC, the BF of the 8yo SS, the BF of the 4yo SS and the SM. CCDSS assessed the safety of the SS and learned they were in the custody of their BFs and visited regularly with the SM at her home. CCDSS coordinated with another county to assess the safety of the PS's 2 children, that resided in that county with their BM.

The SS and the PS's two children were interviewed. None of the children were at the SC's home at the time of the fatal incident. The children did not reveal any concerns. CCDSS were unable to visit the home of the SC because of an ongoing LE investigation. LE shared photos of the home with CCDSS and no safety concerns were noted.

LE said the PS smelled of alcohol when they were at the home. The PS said he had given the SC "Benadryl" without reason. The PS told LE that on the evening of 4/19/18 he was in the living room watching a movie and the SC was in her bedroom playing. The PS heard a loud noise and went to check on the SC. The PS reported finding the SC lying on the bedroom floor, and he carried her into the living room. The PS and SC played for a bit and then the SC fell asleep on the couch. The PS went to move the SC into her bed and realized she was not breathing, so he called 911. LE saw vomit on both shoulders of the PS's shirt, and he said the SC vomited when he performed CPR. CCDSS interviewed the PS in jail, and he did not provide any explanation of the events surrounding the fatal incident. The PS said he had been advised by his attorney not to discuss the fatality. He reported 4/19/18 was a "normal day" and he cared for the SC while the SM worked. He denied ever using physical discipline with the SC or her SS.

The SM stated that on 4/19/18 the PS, accompanied by the SC, drove her to work at 2:30PM. The SM reported the SC did not have any new bruises, other than those she was aware of from normal childhood injuries. That was the last time the SM saw the SC. SM sent the PS a text message at 5:45PM, and received a return text at 7:15PM. At that time the PS reported the SC had fallen off the top bunk of the bed and was fine aside from a cut on her chin. The PS also said the SC seemed tired and the SM advised him not to let the SC go to sleep as she had hit her head. The SM reported the SC had recently fallen off the bunk bed ladder, and the SM reminded her she should not climb up the bed. The SM denied she had ever seen the SC on the top bunk. The SM checked back in with the PS later in the evening and he said the SC was sleeping next to him on the couch. The SM said LE then arrived at her place of employment and transported her to the ER, where she was informed the SC was deceased. The SM denied knowledge of the PS using alcohol that evening, or giving the SC Benadryl. The SM realized when speaking with LE that she had missed a text message from the PS that night. The text read "she's really hurt". Initially the SM did not believe the PS had hurt the SC, but as evidence was reviewed with her it became apparent the SC had suffered blunt force trauma. The SM severed her relationship with the PS. There was an OP put in place on 4/23/18 against the PS on behalf of both SS, until they are 18 years old.

Upon arrival at the SC's home, EMS said the SC's extremities were cold and her chest was warm. The SC had small bruises all over her body. The SC did not have vomit in her mouth and her airway was unobstructed. EMS said the timeline provided by the PS was not accurate given the physical condition of the SC.

CCDSS spoke with family members, doctors and service providers. There were no concerns expressed regarding the care the SC in the time leading up to her death. It was determined the SM was not a risk to the SS and unsupervised visits resumed.

Official Manner and Cause of Death

Official Manner: Homicide

Primary Cause of Death: From an injury - external cause

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046705 - Deceased Child, Female, 2 Yrs	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	Swelling / Dislocations / Sprains	Substantiated
046705 - Deceased Child, Female, 2 Yrs	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
046705 - Deceased Child, Female, 2 Yrs	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	Fractures	Substantiated
046705 - Deceased Child, Female, 2 Yrs	047195 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
046705 - Deceased Child, Female, 2 Yrs	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	Internal Injuries	Substantiated
046705 - Deceased Child, Female, 2 Yrs	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	Lack of Supervision	Substantiated
046705 - Deceased Child, Female, 2 Yrs	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	DOA / Fatality	Substantiated
046705 - Deceased Child, Female, 2 Yrs	047195 - Mother, Female, 26 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
046705 - Deceased Child, Female, 2 Yrs	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	Lacerations / Bruises / Welts	Substantiated
046705 - Deceased Child, Female, 2 Yrs	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	Inadequate Guardianship	Substantiated
047197 - Sibling, Female, 4 Year(s)	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
047197 - Sibling, Female, 4 Year(s)	047195 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
047198 - Sibling, Male, 8 Year(s)	047195 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
047198 - Sibling, Male, 8 Year(s)	047326 - Other Adult - Parent Substitute, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	\boxtimes			
When appropriate, children were interviewed?	\boxtimes			
Alleged subject(s) interviewed face-to-face?	\boxtimes			



All 'other persons named' interviewed face-to-face?	\boxtimes			
Contact with source?	\boxtimes			
All appropriate Collaterals contacted?	\boxtimes			
Was a death-scene investigation performed?	\boxtimes			
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?	\boxtimes			
Was there timely entry of progress notes and other required documentation?				
Fatality Safety Assessment Activities				
				Unable to
	Yes	No	N/A	Determine
Were there any surviving siblings or other children in the household?	\boxtimes			
Was there an adequate safety assessment of impending or immediate dang in the household named in the report:	ger to sur	viving sib	lings/oth	er children
Within 24 hours?	\boxtimes			
At 7 days?	\boxtimes			
At 30 days?	\boxtimes			
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	\boxtimes			
Are there any safety issues that need to be referred back to the local district?				
		Γ	Γ	I
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?				
E-talita Diala Assessment / Diala Assessment /	D #1.			
Fatality Risk Assessment / Risk Assessment 1	rome			
	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?				

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Were appropriate/needed services offered in this case				\boxtimes				
vvere appropriate/needed services offered in this case								
		Placement Activities in Response	e to the Fatal	ity Inves	tigatio	n		
								Unable to
					Yes	No	N/A	Determine
siblings/other children	ı in th	case show the need for the surve household be removed or place fatality investigation?		r				
8		en in the household that were r port / investigation or for reaso		I				
		Legal Activity Relat	ed to the Fat	ality				
		Dogar Renviry Relat	ou to the I at					
Was there legal activit ⊠Family Court	y as a	result of the fatality investigati Criminal Court	ion?		⊠Ord	er of Prote	ection	
Family Court Petition	Тур	e: FCA Article 10 - CPS						
Date Filed:	Fac	ct Finding Description:		Disposi	ition E	Descriptio	n:	
	The	ere was not a fact finding		There v	vas no	t a disposi	tion	
Respondent:	047	2326 Other Adult Male 29 Year(s))					
Comments:								
Criminal Charge: Mu	rder	Degree: 2						
Date Charges Filed:		Against Whom?	Date of Disposition:			Disposit	ion:	
Unknown		Parent Substitute P	Pending			Pending		
Comments:		This charge was brought against	the PS rega	rding th	e deat	h of the S	C.	
Criminal Charge: Ma	nslaug			• . •				
Date Charges Filed:			Date of Disposition:				Disposition:	
Unknown	Parent Substitute Pending Pending							
Comments:		This charge was brought against	the PS rega	rding th	e deat	h of the So	<u>C.</u>	
Criminal Charge: Cri	minal	ly negligent homicide Degree :	: NA					
Date Charges Filed:			Date of Disposition:			Disposition:		
Unknown			Pending				Pending	
Comments: This was an initial charge before the autopsy results were known.								

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Criminal Charge: Endangering the welfare of a child Degree: NA				
Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:	
Unknown	Parent Substitute	Pending	Pending	
Comments: This was an initial charge before the autopsy results were known.				

Have any Orders of Protection been issued? Yes				
From: Unknown	To: Unknown			
Explain:				
An Order of Protection was requested against the DS regs	ording the 2 SS, until the time that they are each 18 years old			

An Order of Protection was requested against the PS regarding the 2 SS, until the time that they are each 18 years old. The matter was adjourned in court during the CPS investigation. At the time of this writing the investigation was closed so the dates for the order were unknown.

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						\boxtimes	
Mental health services							
Foster care							
Health care						\boxtimes	
Legal services							
Family planning							
Homemaking Services							
Parenting Skills							
Domestic Violence Services							
Early Intervention							
Alcohol/Substance abuse							
Child Care						\boxtimes	
Intensive case management	\boxtimes						
Family or others as safety resources							
Other							

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Additional information, if necessary:

The SM was voluntarily engaged in several recommended services offered by various providers, including MH, grieving support group and parenting classes.

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?	Yes
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/19/2017			Inadequate Guardianship	Unsubstantiated	No
		1	Inadequate Guardianship	Substantiated	
		·	Lack of Supervision	Substantiated	

Report Summary:

An SCR report was received stating the PS failed to supervise his then 2-year-old child and the child ingested the PS's mother's medication. As a result the child had slurred speech and was unable to stand. The PS's mother left the medication on a windowsill and therefore it was accessible to the child. The PS was not adequately supervising the child.

Report Determination: Indicated Date of Determination: 03/30/2017

Basis for Determination:

ECDSS found credible evidence to support the allegations against the PS. The child resided with his BM and was on a visitation at the PS's home. The medication was not put away and was within reach of the child. The PS was aware his mother had left the home and also that she kept her medication on the windowsill. The PS allowed the child to play unsupervised in the room where the medication was kept. The child was taken for medical attention and treated after ingesting medication. The PS's mother purchased a locked box and kept it out of the child's reach, after the incident.

OCFS Review Results:

The source was contacted, and appropriate collaterals contacted. All adults were provided notice of existence and interviewed. Concerns that arose during the investigation were addressed.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
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01/04/2016	Sibling, Female, 2 Years	Other Adult - grandmother to youngest SS, Female, 48 Years	Lacerations / Bruises / Welts	Unsubstantiated	No
		Other Adult - grandfather to youngest SS, Male, 51 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - BF to youngest SS, Male, 23 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	1 0	Other Adult - Uncle to youngest SS, Male, 19 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - grandmother to youngest SS, Female, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - grandfather to youngest SS, Male, 51 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - BF to youngest SS, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	
		Other Adult - Uncle to youngest SS, Male, 19 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

An SCR report was received alleging that while the youngest SS was visiting her BF, PGF and PGM she sustained bruises to her buttock. There was no explanation for the bruising.

Report Determination: Unfounded Date of Determination: 03/16/2016

Basis for Determination:

There were small bruises found on the SS, but no evidence that the BF, PGF or PGM inflicted the marks. It is unknown when the bruises occurred, and may have occurred while in the SM's care. There was an ongoing custody battle between the SM and BF of the SS, that may have resulted in continuous calls to the SCR.

OCFS Review Results:

Casework was commiserate with the case circumstances. All children were seen and interviewed when age appropriate. All subjects and other people named on a report were notified and interviewed.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/18/2015	Sibling, Female, 2 Months	Male, 22 Years	Guardianship	Unsubstantiated	
	0,	Other Adult - BF of youngest SS, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	,	Other Adult - BF of youngest SS, Male, 22 Years	Other	Unsubstantiated	
	Sibling, Female, 2 Months	Mother, Female, 23 Years	Other	Unsubstantiated	

Report Summary:

An SCR report was received that alleged the BF of the youngest SS was using illicit drugs while the SS was with him for visitation. The BF had used drugs to the point of impairment while acting as the sole caretaker for the SS.

There was an additional SCR report received on 11/20/2015 as a result of a court ordered investigation. The subsequent report was consolidated with the open investigation.

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Report Determination: Unfounded	Date of Determination: 01/28/2016
	-

Basis for Determination:

The BF of the SS denied any drug use and there was no evidence to the contrary. The BF at times went to his girlfriend's home while he had the SS for visitation, and he reported leaving the SS with his parents as caretakers. The grandparents were deemed appropriate caregivers. The SM and BF were having a custody dispute at the time of the investigation.

OCFS Review Results:

The allegations that arose during the investigation were addressed. The eldest SS and SC were also living in the SM's home at the time of the investigation, but were not added to the report. The BF's of the SC and SS were also not added to the report or provided a notice of existence letter.

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

Issue:

Failure to provide notice of report

Summary:

A notice of existence was not provided to an other adult listed on the report, in addition to the BF of the eldest SS and the BF of the SC. The notice of existence letters were not provided to all appropriate individuals for the initial, nor subsequent report.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

CCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

There were children living in the SM's household at the time of the investigation that were not added to the household composition.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

Action

CCDSS will add all children that are residing in a home to the investigation, in an effort to assess safety and determine future risk.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/05/2015	Sibling, Female, 1 Years		Lacerations / Bruises / Welts		
	Sibling, Female, 1 Years	Father, Male, 31 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 1 Years	Hather Male 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	IMother Remale 73 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 23 Years	Other	Unsubstantiated	



Sibling, Female, 1	Other Adult - BF of youngest SS,	Other	Linguhatantiatad
Years	Male, 23 Years	Other	Onsubstantiateu

Report Summary:

An SCR report was received alleging the youngest SS had fingerprint bruising to the left side of her face and top of her left ear. The SM and BF of the SC were caring for her at the time, and had no explanation for the injury. The eldest SS, SC and BF of the SS had unknown roles.

A court ordered investigation was called in as an SCR report on 8/6/2015. The allegations were consolidated into the open report.

Report Determination: Unfounded Date of Determination: 10/14/2015

Basis for Determination:

There was no evidence found that the marks on the SS's face were inflicted. The SS was taken to 2 doctors for examination and reported the marks on her face were not inflicted. The doctor reported the SS had been violently vomiting a few days before and suffered petechiae from this event. The SS's BF filed for custody of the SS at the during the investigation. The Family Court Judge ordered a 1034 investigation. There were no concerns found in either home. The BF of the SC went to rehabilitation for a drug addiction. The SM was offered services for diagnosed MH issues, but she refused. The SM reported she does not require intervention and had the illness managed.

OCFS Review Results:

The casework was commensurate with the case circumstances. Appropriate collaterals were contacted and all subjects and others named in the report interviewed. The safety and risk assessments were completed timely and accurately. Notice of existence letters were sent to everyone except the BF of the SC, although he was named a subject in the report.

Are there Required Actions related to the compliance issue(s)? \(\subseteq \text{Yes} \quad \text{No} \)

Issue:

Failure to provide notice of report

Summary:

CCDSS did not provide the BF of the SC a notice of existence of the SCR report, although he was in the household and named as an alleged subject.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

CCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

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

12/14/10- An SCR report was received with allegations of IG and PD/AM against the PS regarding his child (OC).

5/10/12- An SCR report with allegations of IG, OTH, LS Unsub against OA regarding the eldest SS and LS and IG Unsub against SM regarding the same SS. The allegation of IG was Sub against the BF of the SS regarding the SS.

8/5/12- An SCR report with allegations of LS and IG Unsub against the SM and BF of the SS, regarding the SS.

12/20/12- An SCR report with allegations of IG and OTH Sub against the SM regarding the eldest SS and the same allegations Unsub against the BF of the SS regarding the same SS.

1/9/13- An SCR report with allegations of IG and OTH Sub against the SM regarding the SS and OTH Unsub against the BF of the SS regarding the SS.

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3/13/14- An SCR report with allegations of IG, PD/AM and LS Sub against the BF of the eldest SS, regarding the eldest SS and IG and PD/AM Sub against the BF re the other SS. An allegation of IG was all Sub. against the SM regarding both SS.

SS.

7/18/14- An SCR report with allegations XCP, IG, PD/AM Unsub against the BF of the SS regarding the SS.

Known CPS History Outside of NYS

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

Preventive Services History

A voluntary Preventive Services case was opened on 12/02/2009 at the request of the SM. The SM was expecting her first child (the eldest SS) and she and the BF were living together. The SM asked for services as she was a young mother and did not have a lot of familial support. In the short time the case was open home visits were made, but no FASPS were completed. The case was closed on 02/05/2010 as they no longer wanted services.

A Preventive Services case was opened 12/28/2012 as the result an indicated report against the SM with concerns with her behavior toward the eldest SS. The BF of SS gained custody of the SS and the SM had visitation. The SM met with LDSS and began attending MH counseling. The SM asked that her case be closed as she no longer required services and did not have custody of the SS. The case was closed 3/06/2013.

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? \square Yes \boxtimes No

Are there any recommended prevention activities resulting from the review? \square Yes \boxtimes No

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