Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-17-061

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

Issue Date: Jun 06, 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: 7 year(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 12/25/2017
Initial Date OCFS Notified: 12/29/2017

Presenting Information

On December 23, 2017, SM and SC were walking down the side of a road. When the mother tried to avoid a pothole, she and SC went into the road and both were struck by a vehicle. The mother failed to act appropriately to protect SC. As a result, SC sustained serious internal head injuries. SM was subsequently pronounced dead. SC was transported to a hospital and was intubated. On December 28, 2017, SC was removed from life-support and was pronounced dead due to the injuries sustained. Unknown named SS and BF have unknown roles.

Executive Summary

This report concerns the death of the 7-year-old female subject child that occurred on 12/25/17. Suffolk County Department of Social Services (SCDSS) received an SCR report on 12/29/17 regarding the fatality, subsequent to an open CPS investigation. The report alleged that on 12/23/17, subject mother failed to protect her child when she and the subject child were walking in the street, presumably to avoid a puddle, when struck by a car moving at about 45 miles per hour. Due to injuries sustained from the accident, the mother was pronounced deceased on 12/23/17. The subject child was immediately placed on life support and was pronounced brain-dead on 12/25/17 at 5:20PM. The biological father was incarcerated and was permitted to visit subject child at the hospital. He signed consent for a medical procedure for the subject child. The subject child remained on life support until 12/28/17.

An autopsy was performed by the ME on 12/29/17. The ME determined the cause of death to be Blunt Force Trauma due to being struck by a motor vehicle. The manner of death was ruled accidental. SCDSS coordinated their investigative efforts with LE. LE investigated the fatality and no criminal charges were brought against the driver.

Upon the death of the subject mother, the maternal grandmother immediately obtained custody of the 9yo surviving sibling, and together they moved into the maternal aunt’s home with the maternal aunt, 12yo maternal aunt, and maternal cousin. The home was assessed to have no safety concerns.

At the time of the fatality, a 9yo female surviving sibling lived with her maternal grandmother, 12yo maternal aunt, adult maternal aunt, and 16yo maternal cousin. Within 24 hours, SCDSS attempted to contact the family and was unsuccessful. SCDSS was unable to assess the SS' safety within 24 hours of receiving the report. On 1/3/18, SCDSS contacted the MGM and assessed the safety of the SS. The SS was not seen or spoken with by SCDSS until 1/11/18. Although the surviving sibling was not adequately interviewed, enough information was obtained to determine the surviving sibling was safe with her family.

SCDSS found no evidence that the mother caused or contributed to the death of the child, and therefore unsubstantiated the allegations received in the report. During the investigation, the maternal grandmother sought out assistance from SCDSS in obtaining emergency shelter as the maternal aunt's home was too crowded. SCDSS opened a Preventive Services case at the request of the grandmother. SCDSS assisted the family with emergency shelter and daycare services for the surviving sibling. The surviving sibling was receiving counseling services from her school social worker. Additional services offered were bereavement services and burial assistance, which were declined.

PIP Requirement

SCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) SCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, SCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** No
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Details of the events leading up to the fatality were not explored with collateral contacts, such as the driver, witnesses and family members. There was no documentation of the SS's safety being assessed within 24 hours of the receipt of the fatality report.

Required Actions Related to the Fatality

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

Issue:	Review of CPS History
Summary:	There was no documentation of an SCR history check for the family or fathers within 24 hours of receiving the fatality report. The SCR history check was completed on 1/25/18.
Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	Within 1 business day of a report, SCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, SDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:	Failure to provide notice of report
Summary:	SCDSS did not provide Notice of Existence letters to MGM and the SS's biological father within 7 days of the receipt of the fatality report. The SCR report was received on 12/29/17; however, the letters were not generated until 1/25/18.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	SCDSS will mail or deliver notification letters to subject(s), parent(s), and other adults named in the report within the first 7 days following the receipt of the report.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The SC's BF was added to the report, yet no efforts to speak with him were documented. The interviews with MGM and SS lacked basic information to assess general safety and risk such as PA/DM, discipline and domestic violence.
Legal Reference:	432.1 (o)
Action:	SCDSS will make efforts to make casework contacts with biological parents and/or persons named in a report. Interviews with SS were not documented to elicit sufficient information to assess safety factors regarding her home-life.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	Interviews were not documented to have been conducted with all appropriate collateral contacts, including family members who lived with SS. There were no documented attempts to contact the driver of the car who struck SM and SC.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	SCDSS will make collateral and familial contacts, address all potential areas of concerns with all relevant parties, and adequately monitor any concerns.
Issue:	Face-to-Face Interview (Subject/Family)
Summary:	At the time of the SCR report, SS was living with MGM, 12yo MA, adult MA, and 16yo MC. MGM had obtained emergency custody of SS. The family members were never interviewed or added to the report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	Although SCDSS was involved with the family at the time of the fatality, the safety of the SS was not assessed within 24 hours of the fatality report. SCDSS made home visits to no avail. SCDSS contacted MGM to assess safety of the SS on 1/3/18.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	SCDSS will adequately assess safety of children respective to case circumstances within 24 hours of each SCR report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/25/2017 **Time of Death:** 05:20 PM

Date of fatal incident, if different than date of death: 12/23/2017
Time of fatal incident, if different than time of death: 00:00 PM

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: 05:04 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: The child was walking in the roadway.

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	7 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)
Other Household 2	Aunt/Uncle	No Role	Female	34 Year(s)
Other Household 2	Aunt/Uncle	No Role	Female	16 Year(s)
Other Household 2	Grandparent	No Role	Female	52 Year(s)
Other Household 2	Other Child - Maternal Cousin	No Role	Female	12 Year(s)
Other Household 2	Sibling	No Role	Female	9 Year(s)
Other Household 3	Father	No Role	Male	31 Year(s)

LDSS Response

On 12/23/17 at about 5:05PM, SM and SC walked onto a busy roadway, seemingly to avoid a puddle and were struck by a car moving at about 45 miles per hour. The exact speed limit and amount of traffic on the road at the time of the accident was unknown; however, an EMS Chief reported it was an appropriate speed on the road. EMS reported that SM and SC

were observed to be holding hands and moving in the same direction as traffic.

Immediately following the accident, SM was pronounced deceased at the hospital and SC was revived once. The SC was transported to another hospital due to their strong Pediatric Intensive Care Unit. SC sustained severe, life threatening injuries, including a broken vertebra. According to hospital staff, SC was intubated and placed on life support. The hospital staff did not expect the SC would survive through the night.

SCDSS was made aware of the incident on the same day and began their investigation. After unsuccessful home visits, SCDSS contacted the MGM on 12/24/17 and obtained information that the SS was in and would remain in her care. On 12/26/17, SC was observed at the hospital; she was on life-support. The SS was observed on the same day, in the care of her MGM, and SCDSS found no safety concerns.

According to EMS, the driver and witnesses assisted SM and SC by performing CPR. Immediately following the accident, SM and SC were transported to the hospital via ambulance. LE ruled the incident accidental and found no information that SM was acting in a negligent or unsafe manner. LE considered poor visibility due to rain, poor lighting, and the dark clothing of SM and SC to be contributing factors of the accident. LE took a statement from the driver. The record shows that SCDSS requested a copy of the statement on 1/3/18, but LE denied the request for unknown reasons. LE did provide the SCDSS with verbal information regarding what the driver had said. LE stated the driver saw SM and SC walking and when the driver was about to swerve away from them, they walked right in front of her car and she hit them both.

The BF was incarcerated at the time of the accident and was transported to the hospital to see SC. On 12/25/17 at 5:20PM, SC was pronounced brain-dead, while MGM and BF were by her side. The BF signed consent for SC's medical procedure. During the investigation, information was obtained from MGM that she obtained custody SS and BF was in agreement. A custody agreement regarding SS was not arranged for after the BF's release from prison. SCDSS did not document attempts to contact the SC's BF, although he was added to the case and provided notification of the report. The BF of the SS stated the SM and SC visited him in prison hours before the incident, yet could not provide information on where SM and SC were going after the visit ended.

At the time of the SM's death, MGM and SS moved in with the 12yo MA, adult MA and 15yo MC. The SS was assessed to be safe with her family. A CPS history check was completed on 1/25/18 which verified that MGM was an appropriate caregiver for the SS.

On 12/29/17, SCDSS received an SCR report regarding the death of the SC, who was taken off life support on 12/28/17. Within 24 hours, SCDSS attempted to contact the family and was unsuccessful. The source was contacted and the ME was notified of the death of the SC on 1/3/18. LE was already aware of the death of the SC due to their involvement since the night of the incident. On 1/3/18, SCDSS contacted the MGM to notify her of the fatality report. SCDSS saw the SS on 1/11/18 and she reported being safe with her family. Per the request of the MGM, the SS was not interviewed prior to the funeral of SM and the SC. Conversations with the SS thereafter did not provide any additional information.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: SCDSS notified the ME of the fatality and coordinated investigative efforts with LE.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Suffolk County has no approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045467 - Deceased Child, Female, 7 Yrs	045468 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
045467 - Deceased Child, Female, 7 Yrs	045468 - Mother, Female, 31 Year(s)	Internal Injuries	Unsubstantiated
045467 - Deceased Child, Female, 7 Yrs	045468 - Mother, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated

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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Other	☐	☒	☐	☐
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:
SCDSS did not assess the safety of the SS within 24 hours of the receipt of the report. The 9yo SS was not observed until 1/11/18 and was not adequately interviewed during the investigation. Although MGM did not approve of SCDSS interviewing SS until after the funeral, SCDSS did not interview her about the death of SC thereafter.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
MGM accepted Preventive Services, daycare services and assistance obtaining emergency shelter.

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:
SCDSS offered the family bereavement, daycare services, emergency shelter assistance and Preventive Services in response to the fatality. The family accepted the services, excluding bereavement as SS was receiving counseling through her school.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
See above.

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?	Yes

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)
12/23/2017	Deceased Child, Female, 7 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unfounded	Yes
	Deceased Child, Female, 7 Years	Mother, Female, 31 Years	Lacerations / Bruises / Welts	Unfounded	
	Deceased Child, Female, 7 Years	Mother, Female, 31 Years	Internal Injuries	Unfounded	

Report Summary:
An SCR report alleged that on 12/23/17, SM and SC were struck by a car while walking around a puddle into the roadway in Yaphank, NY. As a result, SM died. SC sustained severe and life-threatening injuries, including trauma and lacerations to the head.

Determination: Unfounded | **Date of Determination:** 02/21/2018

Basis for Determination:
The injuries of SM and SC were determined to be a result of a motor vehicle accident, and there was no evidence found that SM's actions or inactions caused the death of SC.

OCFS Review Results:
There were instances of insufficient documentation. The SC's BF was not contacted/interviewed by SCDSS. Notice of Existence letters were not mailed/hand delivered within 7 days of the receipt of the report. Conversations with SS and other family members within the home were lacking key safety-related questions; there were no full interviews of the children to assess overall safety and risk. A record check was not documented to be completed in a timely manner.

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

Issue:
Review of CPS History

Summary:
There was no review of SCR history check documented within 1 business day of the receipt of the report. There was no documentation of a CPS history check within 5 business days of the receipt of the report. The report was received on 12/23/17; however, the SCR and CPS history checks were not documented to be completed until 1/25/18.

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

Action:

SCDSS will complete and appropriately document a review of SCR history within 1 business day of the receipt of the report. Further, SCDSS will complete and appropriately document a complete CPS history review within 5 business days of the receipt of the report.

Issue:
Failure to provide notice of report
Summary:
Notice of Existence letters were not documented to have been mailed or hand delivered within 7 days of the receipt of report dated 12/23/17. Notice of Existence letters for MGM, SS's BF or SC's BF were not generated until 1/25/18.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
Conversations with SS and MGM were lacking key safety-related questions. There were no full interviews of the SS or MGM to assess overall safety, risk and allegations were not discussed.
Legal Reference:
432.1 (o)
Action:
SCDSS will incorporate key safety- related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
SCDSS did not document attempts to interview the driver and witnesses to the accident. There were missed opportunities to gather collateral information from family members, including SM's sisters, such as where SM and SC were coming from and going to, or if SM regularly walked with her children. There is no documentation of a conversation with BF.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
SCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/17/2017	Deceased Child, Female, 6 Years	Mother, Female, 30 Years	Educational Neglect	Far-Closed	Yes
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Educational Neglect	Far-Closed	

Report Summary:
An SCR report alleged SS and SC were chronically late to school. They were late 15 days, coming into school 30-90 minutes late and have been absent 4 days. As a result of their attendance issues, the children were failing their first class.

The children were often not picked up from school for up to 45 minutes. SM was contacted regarding the children's attendance, but the issues continued. The report was appropriately tracked FAR and local protocol was followed.

OCFS Review Results:
Biological fathers were not notified or contacted in regard to the case. SCDSS did not document interviews with the children inquiring as to why the children were frequently late to school or why SM is late to pick them up. There was not documentation of questioning surrounding key-safety and risk factors.

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

Issue:
FAR-Failure to Provide Notice of Report

Summary:
The SM identified the fathers of the children, but SCDSS did not send them the required notification of the report regarding their children.

Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:
No later than 7 days after receipt of a child protective report that has been assigned to the family assessment response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/28/2016	Deceased Child, Female, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Female, 6 Years	Mother, Female, 30 Years	Swelling / Dislocations / Sprains	Far-Closed	
	Deceased Child, Female, 6 Years	Mother, Female, 30 Years	Lacerations / Bruises / Welts	Far-Closed	

Report Summary:
An SCR report alleged SM picked SS and SC up from school and became very angry and verbally abusive to her children and staff. SM yelled and called the children names. When she left with her children, she drove very fast. After they got home, mother became angry and pushed SC into the door with force and as a result, SC sustained swelling on her face and a small cut under her right eye. SM was verbally aggressive with the children and constantly yelled and screamed at them. The report was appropriately tracked FAR and local protocol was followed.

OCFS Review Results:
There was no documentation of the biological fathers being notified about the report. Aside from the SC, no children were documented to have been engaged in conversations and key-safety related discussions were not documented.

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

Issue:
FAR-Failure to Provide Notice of Report

Summary:
The fathers were not identified/added to or notified of the report in regard to their children. Written notification was not documented to have been provided to SM.

Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:

No later than 7 days after receipt of a child protective report that has been assigned to the family assessment response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/24/2016	Deceased Child, Female, 6 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Unfounded	Yes

Report Summary:
An SCR report alleged that PS struck SC in the face for unknown reasons. It was unknown if the child sustained any injuries.

Determination: Unfounded **Date of Determination:** 07/27/2016

Basis for Determination:
SC, SM and PS were interviewed and denied SC was struck by PS. During the investigation, SC had no visible marks or bruises on her face or any other part of her body. CW observed SS and SC to have adequate hygiene and to be dressed in age and weather appropriate clothing at every home visit. The home had adequate food and appeared clean and neat. There were no safety concerns.

OCFS Review Results:
SCDSS did not document a SCR history check within 24 hours of receipt of the report. Conversations with SM, PS (BF of SS), SC and SS were lacking key safety-related questions and were solely based on the allegations within the report. The overall completeness of the investigation was inadequate and the investigation was allegation based. SCDSS did not address safety and risk factors including domestic violence and/or parent drug/alcohol misuse. Investigation lacked documented collateral contacts.

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

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

Summary:
This investigation was determined prior to a full assessment of safety and risk factors. While SCDSS did address the concerns of the report, conversations with the family were allegation-focused. SCDSS only addressed the allegations and did not explore any other areas of potential child welfare concerns.

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

Action:
SCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the length of the investigation.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
There was no documentation of contact or attempts to contact the source of the report or contact BF in regard to the report. Documentation states that BF reached out to SCDSS, yet no attempts were documented to interview him as a collateral contact. There were no documented collateral contacts with family, friends or others who may have had information regarding the allegations within the report.

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

Action:

SCDSS will contact or make diligent efforts to contact the source of all SCR reports so as to verify adequacy of report and possibly gain additional information. SCDSS will contact relevant collateral sources.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/13/2015	Deceased Child, Female, 4 Years	Mother, Female, 27 Years	Lack of Medical Care	Unfounded	Yes
	Deceased Child, Female, 4 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unfounded	

Report Summary:
An SCR report alleged that on the night of 4/12/15, SC was brought to the ER for a stiff neck. Upon medical observation, SC was found to have an abscess that required surgery. SM was refusing to have SC transported to another hospital via ambulance placing the child at risk of harm.

Determination: Unfounded **Date of Determination:** 04/20/2015

Basis for Determination:
Investigation revealed that SM was not refusing medical treatment for SC, but did not want to leave her car at the hospital and had to bring SS elsewhere. Additionally, SC did not want to ride in an ambulance. Investigation revealed that SM had every intention to transport SC to another hospital without ambulance assistance. SM was able to obtain appropriate medical treatment for SC and the child recovered within days.

OCFS Review Results:
The biological fathers of SS and SC were not added or notified of the report, and were not documented to have been interviewed. The investigation is not adequate due to the overall safety of the children not being assessed. The family was not asked basic safety questions; there were no full interviews of the children to assess overall safety and risk. SC was seen but not interviewed, and one SS was neither seen nor interviewed. An SCR history check was not completed within 24 hours of the receipt of the report.

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

Issue:
Failure to provide notice of report

Summary:
SCDSS did not provide Notice of Existence letters to the biological fathers or make efforts to speak with them about the report. The biological fathers were not added to the report. SCDSS did not document asking SM about the biological fathers and possible contact information.

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

Action:
SCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
The investigation was allegation driven. The children were observed, but not documented to have been interviewed. The investigation was not adequate due to the overall safety of the children not being assessed. There was no documentation of the caseworker asking the family about general safety and risk factors such as DV, PD/AM, and ample food for the children or parents.

Legal Reference:
432.1 (o)

Action:
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

[redacted]

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

There is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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

Action:	The record inconsistently documented the child's date of death, showing it as 12/25/17 in some places and 12/28/17 in others. When medical issues are present that result in the official date of death being unclear, SCDSS should make diligent attempts to obtain the death certificate with the official determination of the date of death.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No