Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-18-044

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

Issue Date: Mar 25, 2019

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: 15 year(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 10/04/2018
Initial Date OCFS Notified: 10/05/2018

Presenting Information

An SCR report alleged the child had a history of behavioral issues and was on probation. The child stole, used marijuana, skipped school and was failing. The child was often out in the neighborhood, which had significant gang presence and violence. The MGM and the SM were unable to control the child or manage his behavior. On 10/03/18, at approximately 11:45PM, the child was walking from a friend's house to his grandmother's vehicle when he was shot and killed on the street by an unknown suspect. The grandmother attempted to resuscitate the child by performing CPR.

Executive Summary

This fatality report concerns the death of the 15-year-old male child who died on 10/04/18. The child had a history of criminal activity within the community and excessive absences from school. The child was on probation when he died and there was an open Preventive Services case for the mother and children.The child had been living with his maternal grandmother for several months prior to his death; however, the grandmother was never added to the case and was not receiving assistance in managing the child's behavior. Concerns about the mother and grandmother's inability to control the child were included in the report about the child's death. The report also alleged during the night of 10/03/18, the child's whereabouts were unknown for hours, and he was fatally shot in the street by an unidentified person or persons.

Onondaga County Department of Social Services (OCDSS) coordinated efforts with law enforcement upon the receipt of the SCR report. Law enforcement provided minimal information to OCDSS during their homicide investigation. There was no documentation regarding the outcome of the homicide investigation and the suspect(s) remained unknown at the time of this writing.

During the investigation, several home visits were made and the family was interviewed. There were four surviving siblings, who were assessed to be safe in the care of their mother.

On the night of the fatal incident, the maternal grandmother was looking for the child in the neighborhood, as he did not return home by curfew. The child was seen riding his bike in the street and the grandmother was talking to a friend nearby. The siblings were in the grandmother's car, with the subject child riding around it when witnesses reported hearing approximately 25 gunshots. There were no observed injuries to the siblings. The whereabouts of the mother when the shooting happened was unknown.

The grandmother attempted to resuscitate the child until first responders arrived and transported him to the hospital, where he succumbed to his injuries and was pronounced deceased.

An autopsy was performed and the ME listed the cause of death as "gunshot wounds" and the manner of death homicide.

The family was offered funeral assistance, bereavement services, mental health counseling, which they utilized. The mother was offered a drug addiction evaluation due to concerns she abused marijuana in the past.

OCDSS completed and approved all safety assessments timely. Additionally, the 24-hour Fatality Report and 30-day Fatality Reports were completed timely. OCDSS did not make diligent efforts to obtain locating information for the fathers to the children and did not include them in the investigation. Although the safety of the siblings was assessed

during the investigation, there was not an assessment of their safety documented within 24-hours of receiving the SCR report.

The allegations in the report were submitted to be unsubstantiated by OCDSS, but had not yet met supervisory approval. OCDSS documented that there was no credible evidence the child's death was due to any action or inaction by the mother or grandmother. The criminal investigation remained open. OCDSS documented that the grandmother would bring the child to school every day, but he would not enter the school. OCDSS planned have the Preventive Services case remain open for the family as the two oldest surviving siblings started to become physically aggressive in the community after the death.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
Casework activity did not include diligent attempts to locate the fathers of the children.

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

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:
The investigation was pending approval and the Services case remained open at the time of this writing.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment

Summary:	The safety of the surviving siblings was assessed during the investigation, but documentation did not show how safety/risk was assessed within the first 24-hours of the investigation.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	OCDSS will adequately assess and document the safety of children respective to case circumstances within 24 hours of each SCR report.
Issue:	Face-to-Face Interview (Subject/Family)
Summary:	There were missed opportunities to gather information and diligent attempts were not made to obtain information to locate the fathers, including contacting out of state agencies. The fathers may have had information about the care of the children.
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:	Failure to provide notice of report
Summary:	Although OCDSS had the names of the biological fathers and possible locating information, diligent attempts were not made to notify them of the report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	Onondaga County currently has a plan to address this issue, and no further action is required.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/04/2018 **Time of Death:** 12:22 AM

Date of fatal incident, if different than date of death: 10/03/2018
Time of fatal incident, if different than time of death: 11:44 PM

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 11:44 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: riding bicycle

Did child have supervision at time of incident leading to death? Yes
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	15 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	48 Year(s)
Other Household 1	Mother	Alleged Perpetrator	Female	33 Year(s)
Other Household 1	Mother's Partner	No Role	Male	38 Year(s)
Other Household 1	Sibling	No Role	Female	6 Year(s)
Other Household 1	Sibling	No Role	Male	9 Year(s)
Other Household 1	Sibling	No Role	Female	5 Year(s)
Other Household 1	Sibling	No Role	Female	12 Year(s)

LDSS Response

On 10/5/18, OCDSS received the fatality report from the SCR, initiated their investigation within 24 hours and coordinated efforts with law enforcement. OCDSS completed a CPS history check, and notified the ME of the child's death in writing. Additionally, a home visit and telephone call were made to assess the surviving siblings, but were unsuccessful.

OCDSS obtained information from EMS, the hospital, LE, ME, probation, and school staff. LE provided minimal details about the fatality and the results of the criminal investigation remained unknown at the time this report was written. The child's probation officer had no knowledge the child was involved in a gang. Additionally, OCDSS obtained CPS records from Oklahoma, where the family previously resided.

According to EMS records, multiple calls were made to 911 around 11:47PM on 10/3/18. When EMS responded, the fire department was performing CPR and the child was transported to the hospital via ambulance; resuscitation efforts were continued. The child was in cardiac arrest. At 12:22AM on 10/4/18, he succumbed to his injuries and was pronounced deceased. The child had 17 gunshot wounds on his body.

On 10/5/18, OCDSS made a home visit to the maternal grandmother's house and offered her bereavement services. The child lived with his grandmother since November 2017, due to his delinquent behaviors in the community. As a result of his behaviors, the child was on probation at the time of his death. The grandmother stated on the night of the fatal incident, the child did not return home by his 10:00PM curfew, and around 11:00PM she went looking for him, as he did not have a cell phone. The siblings rode along with her, as the whereabouts of the mother was unknown. The grandmother saw the child while she was talking to a friend and he was riding his bike toward her car when several shots were fired.

The mother was interviewed at her home on 10/8/18. She was not documented to have been asked about any information relating to the death or the events leading up to the fatal incident. The siblings were observed, but were not interviewed at that time, nor was their safety documented to have been adequately assessed.

The surviving siblings were seen in school on 10/11/18. The siblings (ages 4, 6 and 9 years) were interviewed together, and did not provide any information relating to the fatal incident or death, but agreed that they are well cared for at home. The children were not documented to have been asked about the fatal incident, and did not want to discuss the death. The

12-year-old sibling was interviewed and said she and her siblings were in the vehicle when shots were fired. She stated that her finger was grazed by a bullet, but there was no evidence of this. She offered information she and her siblings went with the grandmother to look for the child because their mother was not home to supervise them when the grandmother brought them home. She explained the younger siblings were asleep during the incident and never saw what happened to the child; however, this was not documented to have been confirmed. There was no information in the case record regarding anything the 12-year-old sibling may have seen during the shooting. It did not appear that she was asked questions regarding her experience.

On 2/7/19, OCDSS searched New York State databases for information regarding the fathers of the children to no avail. The mother said the fathers remained in Oklahoma; however, OCDSS did not document attempts to contact the fathers using alternative methods, including contacting agencies in their home state of Oklahoma.

Throughout the investigation, OCDSS spoke with the family multiple times and assessed the safety of the children, and offered all identified service needs including mental health counseling, bereavement services, funeral assistance, and a continuation of the ongoing Preventive Services case to address negative behaviors involving the surviving siblings.

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

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The fatality was reviewed by a Child Fatality Review Team approved by OCFS.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047870 - Deceased Child, Male, 15 Yrs	048561 - Grandparent, Female, 48 Year(s)	Educational Neglect	Unsubstantiated
047870 - Deceased Child, Male, 15 Yrs	048563 - Mother, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
047870 - Deceased Child, Male, 15 Yrs	048563 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
047870 - Deceased Child, Male, 15 Yrs	048563 - Mother, Female, 33 Year(s)	Educational Neglect	Unsubstantiated
047870 - Deceased Child, Male, 15 Yrs	048561 - Grandparent, Female, 48 Year(s)	Inadequate Guardianship	Unsubstantiated
047870 - Deceased Child, Male, 15 Yrs	048561 - Grandparent, Female, 48 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?	☒	☐	☐	☐
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 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:
Although a home visit was made within 24-hours of receiving the report, there was not a full assessment of safety noted for the SS. There was no full interview with the grandmother documented regarding the events immediately following the gunshots. With the exception of the 12yo SS, the CHN did not want to talk about the fatal incident; however, information regarding what the 12yo SS saw and heard during the shooting was not documented to have been reflected in the case record.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: Bereavement services, mental health counseling and drug counseling were offered to the family.				

Placement Activities in Response to the Fatality Investigation

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

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Preventive Services							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The siblings were referred to mental health and grief counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother and maternal grandmother accepted funeral assistance, mental health services and bereavement services.

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? Yes
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)
07/20/2018	Sibling, Female, 6 Years	Mother, Female, 33 Years	Lack of Supervision	Far-Closed	Yes
	Sibling, Male, 9 Years	Mother, Female, 33 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 4 Years	Mother, Female, 33 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 6 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 9 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 4 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report received on 07/20/18 alleged the mother did not provide adequate supervision for the siblings (ages 4, 6, and 9 years). The mother left the children home alone and tied the door in an attempt to keep them inside. The children opened the door, left the home, and walked nearly two miles to their maternal grandmother's home. The children were not mature enough to be left home alone. The mother was unaware that the children had left the residence. The children did not sustain injuries.

OCFS Review Results:
The history check and 7-day safety assessment were completed timely. The FLAG was appropriately completed with the family. Not all biological fathers were notified of the report and were not contacted regarding concerns. An abundance of services were offered to the family as concerns arose.

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

Issue:
FAR-Failure to Provide Notice of Report

Summary:
Although the fathers of the children were identified, there was not documentation that the fathers were provided with written notice of the FAR case.

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

Action:
No later than seven 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.

Issue:
FAR-Failure to Provide Notice of FAR Closure

Summary:
Although the mother, her paramour and a father of a sibling were provided with written notice of FAR closure, the fathers of the subject child and other children were not documented to have been provided with written notice.

Legal Reference:
18 NYCRR 432.13 (e)(2)(viii)

Action:
OCDSS will provide written notice of FAR closure will be provided to all adults listed on the SCR report, as well as all parents of children named in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

03/07/2018	Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Educational Neglect	Substantiated	Yes
	Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report received on 03/04/18 alleged the mother was leaving the subject child to babysit his siblings and was missing excessive amounts of school. The subject child failed the eighth grade twice prior to the report date, and was failing all classes again as a result of his absences. The mother was aware of the subject child's absences and not intervene as she was high on synthetic marijuana. The mother encouraged the child to engage in criminal activity, which he did. The subject child was not engaged in psychotherapy to address his oppositional behavior, criminal activity and possible gang involvement.

Report Determination: Indicated | **Date of Determination:** 04/24/2018

Basis for Determination:
OCDSS obtained information regarding the child failing in school due to his excessive absences. Investigation revealed the child was staying home from school to babysit his younger siblings and the mother was not concerned with the child's education. There was no credible evidence to support the allegations of the mother abusing drugs or that the child needed psychotherapy.

OCFS Review Results:
OCDSS conducted interviews and made multiple visits to the home. Appropriate contacts were made to collaterals; however, the record did not show follow-up regarding concerns with the family or the collaterals. The 7-day safety assessment was not completed until approximately 6 weeks after the report was made. There was no documentation the mother of the unrelated child living in the home was contacted or attempted to be contacted. There was no documentation of any attempts to contact biological fathers. OCDSS did not offer services or seek legal advice regarding the child's continuous and excessive absences from school.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-day safety assessment was not completed and approved in Connections until approximately 6 weeks after the required timeframe.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
OCDSS will complete and approve all safety assessments accurately and within the amount of time required. The Safety Assessment tool will be used to further assess safety of the children.

Issue:
Review of CPS History

Summary:

Although OCDSS documented a history check within 1 business day of receiving the SCR report, OCDSS had reason to believe the family had prior CPS involvement in another state and did not request the records. When obtained during the fatality investigation, the records contained possible contact information for the fathers.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

Within 1 business day, ECDSS will review SCR records pertaining to all prior reports involving a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report, including legally sealed unfounded reports. Within 5 business days, ECDSS will review and document all CPS record(s) that apply to the prior reports.

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

Although some collateral contacts were made, OCDSS had information about the SM and MGM's drug use but did not follow up. There was no assessment of the MGM's home although SC resided with her, and no legal consult to discuss options in view of the SM's failure to control the child or meet service goals.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

Collateral contacts will be made, and information that they provide will be investigated. Information revealed will be evaluated to determine if the new information constitutes maltreatment. OCDSS will seek legal consultation when appropriate. OCDSS will attempt to contact all parents of children listed on an SCR report.

Issue:

Failure to provide notice of report

Summary:

Although the fathers were identified, there was not documentation that the fathers were provided with written notice of the SCR report.

Legal Reference:

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

Action:

Onondaga County currently has a plan to address this issue, and no further action is required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/11/2017	Sibling, Female, 11 Years	Mother, Female, 32 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Educational Neglect	Unsubstantiated	
	Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Educational Neglect	Substantiated	
	Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 5 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 11 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 8 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 4 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Childs Drug / Alcohol Use	Unsubstantiated
Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 5 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 15 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 11 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 8 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 4 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged the BM used marijuana to the point of impairment while caring for her children. The BM was not an adequate caregiver for the children as she was unsteady on her feet and incoherent. The BM and the SC were selling drugs out of the home in the presence of the siblings. The SC engaged in unruly and dangerous behaviors in the community, and had broken windows and kicked in doors, and set fires. The BM was aware and did not adequately supervise the SC. The home was in deplorable condition with garbage and old food strewn about. The SC and SS had excessive absences from school and were falling behind academically. The BM was aware and failed to get the children to school.

Report Determination: Indicated | **Date of Determination:** 02/05/2018

Basis for Determination:
The allegations regarding the use and sales of drugs were unsubstantiated. The mother denied any recent drug use and denied she or SC sold drugs. Additionally, she denied the SC was destroying property and the fire set was accidental. The home was observed to be clean after CW intervention. During the investigation, the attendance of SS improved and they denied knowing of drug use or sales. The allegations of IG and EdNeg were substantiated regarding SC. The SC had only attended school 4 days and was living with his MGM after being arrested for breaking and entering. The mother was unable to get the SC to school regularly, or control his behaviors.

OCFS Review Results:
OCDSS completed a CPS history check, conducted interviews and spoke with the source of the report. OCDSS offered OCDSS did not document attempts to contact all biological fathers regarding the report. Additionally, alleged home members, including BM's partner and his child, were not added to the report, notified of it, or interviewed.

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

Issue:
Failure to provide notice of report

Summary:

Written notice of an SCR report was not provided to the adults as required. The mother was provided with written notice 9 days after the receipt of the report. The father of SS4 was notified after approximately a month. The fathers of the other SS and an alleged household member were not documented to have been notified of the SCR report.

Legal Reference:

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

Action:

OCDSS 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:

Documentation did not include interviews of 2 individuals who were alleged to live in the home. The biological fathers were not contacted. There was not documentation of the mother or the SC being interviewed regarding some safety and risk questions, such as having an ample amount of food for the family, domestic violence, supervision or discipline relating to the children.

Legal Reference:

432.1 (o)

Action:

OCDSS will make efforts to make casework contacts with biological parents and/or persons named in a report. Interviews will contain sufficient information to assess safety factors regarding the family's functioning and children's well-being.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day Safety Assessment was not completed until approximately 6 weeks after the receipt of the report.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

OCDSS will complete all Safety Assessments in accordance with regulations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/18/2017	Sibling, Male, 8 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:

An SCR report alleged on 7/2/17, SS2 was treated for a cut on his foot and received stitches. At that time, the child was scheduled for a follow up appointment on 7/5/17 to have the stitches removed and to see if the injury required further treatment. The mother failed to bring SS2 to the follow up appointment and failed to propertly treat the injury. As a result, the child's foot was severely infected. The roles of the other children were unknown.

Report Determination: Unfounded | **Date of Determination:** 09/15/2017

Basis for Determination:

Investigation revealed that the mother brought the child for follow up medical care and his toe was not infected. Additionally, the caseworker observed the antibiotic prescribed to the child and the mother and child were compliant with the doctor's instruction.

OCFS Review Results:
OCDSS initiated the report within 24 hours, contacted the source and obtained additional information from collateral contacts throughout the investigation. A Notice of Existence was provided to the mother approximately 2 months after the receipt of the report. Information regarding the fathers of the children was not obtained, therefore they were not notified of the report or spoken to. The progress notes were not entered into Connections contemporaneously, most of which were entered months after the event date and within 2 days of case closer.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
With the exception of two progress notes, the notes were not entered contemporaneously during the investigation, and were documented up to nearly 2 months after the event date.
Legal Reference:
18 NYCRR 428.5
Action:
All progress notes will be entered as contemporaneously as possible to their event dates.

Issue:
Failure to provide notice of report
Summary:
Written notice of the SCR report was not provided to the fathers of the children, and the mother received written notice of the report more than two months late.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will make diligent efforts to contact absent parents of children named in a report and to provide written notice within 7 days of receipt of the report.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day Safety Assessment was not completed and approved until 54 days after the due date.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
OCDSS will complete and approve all safety assessments in the accordance with regulations.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The record did not contain documentation of diligent efforts to contact the biological fathers of the children. The records received from Oklahoma had specific personal information that may have been used to locate the fathers, who may have had information regarding the care of the children.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
OCDSS will make diligent efforts to contact collaterals, including relatives, 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)	Allegation Outcome	Compliance Issue(s)
05/04/2017	Deceased Child, Male, 14 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 14 Years	Mother, Female, 32 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 32 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 4 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 4 Years	Mother, Female, 32 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 32 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
An SCR report alleged the mother was arrested and remanded to a justice center for destroying property. The mother left the children in the home unsupervised, failing to make a plan for them. The mother left the children home, unsupervised so that she could abuse illicit drugs. While the SC was old enough to be left to supervise the children, he was on probation and was an inappropriate caregiver.

Report Determination: Unfounded **Date of Determination:** 09/15/2017

Basis for Determination:
OCDSS interviewed the mother and the children and did not note any safety concerns despite the mother leaving the children home alone and engaging in criminal activity for which she was arrested and jailed. OCDSS documented that collateral contacts, including the social worker for SS1 and SS2, and medical doctors had no concerns for the safety of the children.

OCFS Review Results:
The report was initiated in a timely manner and a CPS history check was documented. Interviews were appropriate with family and collateral contacts; however, OCDSS did not document attempts to contact the biological fathers of the children, or notify them of the report. A Notice of Existence to the mother was not mailed timely. A significant number of progress notes were not entered contemporaneously. The 7-day Safety Assessment was approximately 3 months late and the Safety Assessments did not accurately reflect the information within the case record. The RAP also did not reflect case circumstances.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP noted the BM had developmentally appropriate expectations of all CHN; however, she admitted to leaving her children, ages 10 and 14, to care for the younger siblings. The 14 year old SC was on probation for behavioral concerns

and was not responsible enough to care for other CHN. The MGM was a caretaker for the children while the BM was incarcerated, which was not reflected in the RAP.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day Safety Assessment did not reflect case circumstances as it did not document the mother's recent and out of control violent behavior. The mother was arrested and incarcerated while the grandmother cared for the children. The 7-day Safety Assessment was not completed until approximately 3 months after the due date.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

OCDSS will complete all assessments and accurately reflect the safety factors that are present. OCDSS will complete and approve all safety assessments in the amount of time required.

Issue:

Failure to provide notice of report

Summary:

OCDSS did not provide Notice of Existence letters to the biological fathers or make effort to speak with them about the report. A Notice of Existence letter was not provided to the mother until approximately one month after the receipt of the report.

Legal Reference:

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

Action:

OCDSS will make diligent efforts to contact parent(s) of children named in a report and will provide written notice, if contact information is available, within 7 days of receipt of the report. OCDSS 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 in accordance with regulations.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

There were 44 out of 56 progress notes that were not entered contemporaneously. Progress notes were entered into Connections up to 122 days after the event date.

Legal Reference:

18 NYCRR 428.5

Action:

All progress notes will be entered as contemporaneously as possible to their event dates.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/17/2017	Sibling, Female, 3 Years	Mother, Female, 31 Years	Inadequate Guardianship	Far-Closed	Yes

Sibling, Female, 4 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Female, 3 Years	Mother, Female, 31 Years	Lack of Medical Care	Far-Closed
Sibling, Female, 3 Years	Mother, Female, 31 Years	Lack of Supervision	Far-Closed
Sibling, Female, 4 Years	Mother, Female, 31 Years	Inadequate Guardianship	Far-Closed
Sibling, Female, 4 Years	Mother, Female, 31 Years	Lack of Medical Care	Far-Closed
Sibling, Female, 4 Years	Mother, Female, 31 Years	Lack of Supervision	Far-Closed
Sibling, Female, 3 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Far-Closed

Report Summary:
An SCR report received alleged SS3 and SS4 had elevated lead levels that could stunt their growth and ability to learn. The normal expected lead level was 5; SS3 level was 10 and SS4 level was 16. Since August 2016, the mother was aware that her home was the source of the lead for the children; however, she did not allow the landlord into the home to remedy the problem. The mother did not provide the children with timely medical attention or follow through with their appointments to monitor lead levels. The home was dirty with garbage, clothes and debris, resulting in a cockroach infestation.

OCFS Review Results:
Upon receipt of the report, OCDSS immediately conducted a home visit and addressed the alleged concerns. The case was appropriately tracked FAR per local protocol. Although the a CPS history check was documented, it was 1 day late and did not include history from the state the family had lived in prior to NY. Although given the names of the fathers of the children, the case record did not indicate there were efforts made to involve the fathers, and they were not mailed Notice of FAR letters. Appropriate collateral contacts were made and community resources were offered to the family including housing assistance and literacy classes for the mother. The FAR case was conducted appropriately.

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

Issue:
FAR-Failure to Provide Notice of Report

Summary:
Although the fathers of the children were identified, there is not documentation that the fathers were provided with written notice of the FAR case.

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

Action:
No later than seven 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.

Issue:
FAR-Failure to Provide Notice of FAR Closure

Summary:
Although the fathers of the children were identified, there was not documentation the fathers were provided with written notice regarding the FAR case closure.

Legal Reference:

18 NYCRR 432.13 (e)(2)(viii)

Action:

Upon case closure, OCDSS will provide written notice to all parents of children listed in FAR cases to notify them of the case closure.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/20/2016	Sibling, Female, 3 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Male, 13 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 2 Years	Mother, Female, 30 Years	Lack of Supervision	Far-Closed	
	Sibling, Male, 7 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 13 Years	Mother, Female, 30 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 3 Years	Mother, Female, 30 Years	Lack of Supervision	Far-Closed	
	Sibling, Male, 7 Years	Mother, Female, 30 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 2 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	

Report Summary:

An SCR report received on 01/20/16 alleged the mother was leaving the children home alone at night. The mother left after the children fell asleep and sometimes did not return until the next morning or afternoon. The children had no way to reach their mother. This occurred on at least 4 or 5 occasions.

OCFS Review Results:

OCDSS tracked the report FAR appropriately and in a timely manner. A CPS history check was completed and home visits were made. The case record does not show attempts to obtain contact information for the biological fathers to inform them of the open FAR case. A 7-day safety assessment was not completed until 14 days after the receipt of the report.

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

Issue:

FAR-Failure to Provide Notice of Report

Summary:

Although the fathers of the children were identified, there is not documentation that the fathers were provided with written notice of the FAR case.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:

No later than seven 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.

Issue:
FAR-Failure to Provide Notice of FAR Closure
Summary:
Although the fathers of the children were identified, there is not documentation that the fathers were provided with written notice the FAR case was closed.
Legal Reference:
18 NYCRR 432.13 (e)(2)(viii)
Action:
OCDSS will provide written notice notifying all parents of FAR case closure.

Issue:
FAR-Timely/Adequate 7-Day Assessment
Summary:
The 7-day safety assessment was not completed and approved until 14 days after the deadline. There was not documentation regarding discipline for the children or an assessment of ample food for the family, therefore, the responses documented in the safety assessment appeared to be based on assumptions.
Legal Reference:
18 NYCRR 432.13 (d)(2)(i) and (ii); 18 NYCRR 432.13(d)(3)
Action:
OCDSS will complete and approve all safety assessments within the allotted timeframe. Additionally, OCDSS will document all information gathered during the case in accordance with regulation. OCDSS will document all information into the Connections case record.

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

There was no CPS history in New York State more than three years prior to the fatality.

Known CPS History Outside of NYS

The family had a child protective history with the Oklahoma Department of Human Services. The reports were all closed and documented to be unsubstantiated.

In 2009, there were two reports against the mother regarding the mother's marijuana abuse while pregnant for SS3. The mother denied using marijuana in the presence of her children after the birth. There were concerns that the mother did not provide supervision to the subject child, SS1 and SS2 and allowed them to go to a community center without supervision.

The family had three reports in 2013 regarding concerns the mother and the father of SS4 were abusing marijuana and "powder" in the presence of the children. The mother tested positive for marijuana when SS4 was born. After the birth, the family denied abusing drugs in the presence of the children. Additionally, there were concerns that the father of SS4 physically disciplined the children and leaving marks. The marks were later identified to be bug bites. Domestic violence between the couple was reported. There were concerns the SC was touching other children under their shirts, but the family was not able to be located for the investigation.

In 2014, there were two child protective reports made. There were concerns the mother and father of SS4 were abusing

cocaine and marijuana in the presence of the children. There were allegations the home was infested with bed bugs, and the mother was using money for the utility bills to purchase drugs.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 03/22/2017

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The most recent required FASP was approved 16 days late.				

Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
Coordinated Care Promise Zone FSS were provided to the family. The case record noted the whereabouts of the SC were often unknown, there were concerns of the MGM's drug abuse and possible domestic violence concerns were not addressed.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Adequacy of case recording in FASP
Summary:	Plan amendments were not made throughout the FSS. The child moved several times since the case was opened, and was not reflected in the FASPs. Additionally, there was no plan amendment following the child's death.
Legal Reference:	18 NYCRR 428.6(a)
Action:	OCDSS will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.
Issue:	Mandated reporters did not report potential abuse or maltreatment of a child
Summary:	Although documented throughout the record, concerns brought to the Department's attention included excessive school absences, domestic violence, drug abuse, and lack of supervision, were not always reported to the SCR nor addressed with the family.
Legal Reference:	SSL 413 and 415
Action:	Social services workers are required to report or cause a report to be made, in accordance with regulation, when reasonable cause to suspect that a child is an abused or maltreated child where a person comes before them in their official capacity and states from person knowledge, facts, conditions or circumstances, if correct, would render the child an abused or maltreated child.

Preventive Services History

An Preventive Case was opened from 06/30/16-10/16/18, due to the SC's behaviors in school and in the community. The SC was skipping class, assaulting students, and not following rules. The SC was arrested for theft. He was ordered by Onondaga Family Court to be placed in a secure juvenile correctional facility until his court date when he was ordered to 1 year of probation and was on house arrest on 10/05/16. On 10/26/16, the FSS was closed by OCDSS due to both the SC and the mother's noncompliance with Services.

On 03/22/17- Present After being referred by a CPS worker, a Preventive case was opened due to the SM's illiteracy, the family's lack of consistent supports, and the SC's behaviors of running away and truancy. Additionally, the 4 and 5-year-old siblings tested high for lead levels and did not have a primary care doctor established. During the FSS, the family continued to be non-compliant, the 11-year-old sibling had excessive school absences and the SC had missed more than 90 days of school. Several additional concerns were documented, including the MGM using crack-cocaine and the SM's role in physical and verbal altercations with her partner, both in the presence of the children. These concerns were not always reported to the SCR, and did not appear to be addressed with the family.

Legal History Within Three Years Prior to the Fatality

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

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 3 - JD		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	Although there was documentation through the Preventive Services case that notes the child was court ordered into placement on several occasions, there were no details regarding any petition filed, parties involved, or court outcomes. There was no legal activity entered into Connections.	

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