Child Fatality Report

Report Identification Number: SY-22-053

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

Issue Date: May 25, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 8 year(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 12/19/2022
Initial Date OCFS Notified: 12/19/2022

Presenting Information

Two SCR reports were received 12/19/22, alleging that the subject child had been sick for a few weeks. The child did not eat but took in fluids. For the past couple days, the child had constant vomiting, diarrhea, trouble walking, and a fever around 103. The child's condition was getting worse. On 12/19/22, the child collapsed in the presence of her mother, grandmother, and sibling. The mother initiated cardiopulmonary resuscitation and EMS responded to the home. EMS initiated life saving measures and transported the child to the hospital, where she was pronounced dead at 7:07AM. The mother, stepfather, and grandmother failed to seek timely medical treatment for her. Additionally, the condition of the home was deplorable and was not an adequate and safe living environment for the children.

Executive Summary

This report concerns the death of the 8-year-old subject child. Onondaga County Department of Children and Family Services (OCDCFS) received two SCR reports regarding the child's death on 12/19/22. At the time of the child's death, she resided with her mother and stepfather. Her 17-year-old sibling resided next door with the maternal grandmother, who had custody of the sibling.

The subject child had been ill with a cough for weeks. Around 12/7/22, she spiked a fever, which was treated with over-the-counter Motrin. The child's symptoms continued and included an ongoing fever, vomiting, encopresis, and overall weakness. Although the child was drinking water, she was unable to eat and was vomiting spontaneously. In the days leading up to her death, the child had eaten a few bites of fruit and was weak to the point she required assistance moving. Medical intervention in response to her symptoms was not sought as the mother said there was a two month wait for a sick-visit, and the emergency room reported a 15 hour wait. The family continued to treat the child's symptoms at home. On the morning of 12/19/22, while being helped from the bathroom by her grandmother, the child collapsed. The sibling was there as well and both he and the grandmother attempted to pick up and walk the child back to the chair; however, she collapsed again. The grandmother informed the mother, who called 911 at 6:31AM. EMS responded to the home and the child was transported to the hospital where she was pronounced dead at 7:07AM.

The medical examiner was notified and performed an autopsy. The cause of death was Invasive Group A Streptococcal infection in setting of otitis media and nasopharyngeal swab PCR detection of influenza AH3. The manner of death was considered natural. There was no trauma contributing to the death noted. Law enforcement was notified and began an investigation.

OCDCFS made a home visit the day the reports were received and found the home to be in deplorable condition. A marijuana grow operation was observed and confiscated by law enforcement. There was excessive clutter, old food, beer bottles, medicine bottles, dead mice still attached to traps, and the kitchen counters were so cluttered one could not see the sink. The bathroom sink was covered with black ash, cigarette butts, and a marijuana bowl. Law enforcement's investigation remained ongoing.

OCDCFS assessed the safety of the sibling, which resulted in the need for a safety plan. A safety plan was put in place that day. Due to the condition of the home and the delay in seeking medical care, family court was accessed 12/22/22, Neglect Petitions were filed, and the sibling was placed via FCA 1017 with a relative.

The family was provided bereavement services and the sibling was engaged in counseling prior to the investigation

closing. It was unknow if the parents engaged in services as the parents' attorneys did not permit OCDCFS to communicate with their clients other than via letters.

OCDCFS found a fair preponderance of evidence to substantiate the allegations against the parents and grandmother. The subject child had been sick for some time and her condition deteriorated in the weeks leading up to her death. The child last received medical care in early November 2022 and died 12/19/22. OCDCFS concluded the adults failed to obtain medical care for the subject child despite having access to such services. Emergency care was not sought despite knowing the child's food and fluid intake decreased and the child was dependent on others due to physical weakness. Additionally, the home was assessed to be in deplorable condition and did not meet minimum standards.

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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:
Casework activity was not commensurate with appropriate and relevant statutory or regulatory requirements in that the 30-Day Safety Assessment tool was not documented in Connections. The sibling and 1017 resource were offered ongoing placement services once the sibling turned 18; however, the sibling declined. As there were no longer minor children in the household, the services case was closed.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	Although the sibling's safety in the 1017 placement was routinely monitored through home visits, the 30-Day Safety Assessment tool was not completed in Connections.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	Additional safety assessments must be conducted at the following intervals where there are surviving siblings or other children present in the household; within 24 hours of the receipt of the fatality report and within 30 days of the receipt of the fatality report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/19/2022 **Time of Death:** 07:07 AM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 06:31 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

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

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	Female	8 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Stepfather	Alleged Perpetrator	Male	41 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	63 Year(s)

Other Household 1	Sibling	Alleged Victim	Male	17 Year(s)

LDSS Response

OCDCFS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. The sources of the reports were contacted, CPS history was checked, and the DA was informed of the fatality. OCDCFS assessed the safety of the surviving sibling and determined a safety plan was necessary in which the sibling would stay with a relative. The safety plan was formalized in family court on 12/22/22 following the filing of Neglect against the adults. The sibling was removed on consent and placed pursuant to FCA 1017 with the relative.

All present for the fatal event were interviewed. The mother said the subject child had a cough for the past few weeks, was brought to urgent care and prescribed an antibiotic as her ear was red. On 12/7/22, the child had been sent home sick from school and records indicated she had a fever of 101.4. She returned to school 12/12/22 and was again sent home sick on 12/13/22 with a fever of 102.9, and she was vomiting. The child never returned to school. The mother said the child was drinking and urinating but had diarrhea and her fever had spiked to 103.6. The mother said she called the doctor's office to schedule a sick visit but was told there was a 2 month wait. The mother then called the emergency department and was told there was a 15 hour wait. The mother had planned to take the child to urgent care the day she died. The child had come to stay at the grandmothers, where her sibling resided, as the grandmother had nursing experience. The sibling said his sister had trouble moving, so she just laid on the couch. The days leading up to her death, the grandmother said she would drink water and last ate 2-3 pieces of an apple 2-3 days ago. She was encopretic, vomiting spontaneously, and needed assistance to move. The sibling said he acted as the primary caretaker to his sister until the mother came over 12/17/22 or 12/18/22. The sibling had been directed to give the child Motrin, cold medicine, cough medicine, and an inhaler prescribed to the sibling. The grandmother would direct the sibling which medications to administer. In the early morning of 12/19/22, around 4:00AM, the mother was in the living room with the child. The child had woken the mother multiple times as she either needed a drink of water or to be repositioned. The sibling was called into the living room by the mother because the mother wanted to rest. The sibling then slept in the living room with his sister, and the mother slept in the sibling's bedroom. Around 5:00AM, the child asked to sit in the chair, so the sibling moved her from the couch to the chair. At some point, the grandmother took the child to the bathroom, and while walking back to the living room, the child collapsed. The grandmother called to the sibling for assistance. They took a few more steps and the child collapsed again. The grandmother got the mother, who called 911. They moved the child to the doorway. Upon noticing she was no longer breathing; the grandmother instructed the mother to perform CPR. The sibling waited for EMS outside the apartment.

EMS records indicated the home condition and clutter made it difficult for EMS to walk through. When they arrived, the child was laying supine, on the ground, unconscious, not breathing, and pulseless. EMS had law enforcement carry the child outside. Due to lack of lighting and clutter, EMS was unable to perform interventions in the home. The child was transported to the hospital. Hospital records indicated the child was brought in while EMS was doing cardiac compressions, which began in the field. The child was in full rigor mortis, mottled, cold, and clammy.

The sibling's safety was assessed throughout the investigation and family services stage. The sibling turned 18 during the open case and OCDCFS reviewed ongoing placement options with the sibling, which he declined. The sibling remained living in the relative's home at the time the services case was closed.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063414 - Deceased Child, Female, 8 Yrs	063415 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063415 - Mother, Female, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063415 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063415 - Mother, Female, 34 Year(s)	Lack of Medical Care	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063416 - Stepfather, Male, 41 Year(s)	DOA / Fatality	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063416 - Stepfather, Male, 41 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063416 - Stepfather, Male, 41 Year(s)	Inadequate Guardianship	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063416 - Stepfather, Male, 41 Year(s)	Lack of Medical Care	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063418 - Grandparent, Female, 63 Year(s)	DOA / Fatality	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063418 - Grandparent, Female, 63 Year(s)	Inadequate Guardianship	Substantiated
063414 - Deceased Child, Female, 8 Yrs	063418 - Grandparent, Female, 63 Year(s)	Lack of Medical Care	Substantiated
063417 - Sibling, Male, 17 Year(s)	063415 - Mother, Female, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
063417 - Sibling, Male, 17 Year(s)	063415 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
063417 - Sibling, Male, 17 Year(s)	063416 - Stepfather, Male, 41 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
063417 - Sibling, Male, 17 Year(s)	063416 - Stepfather, Male, 41 Year(s)	Inadequate Guardianship	Substantiated
063417 - Sibling, Male, 17 Year(s)	063418 - Grandparent, Female, 63 Year(s)	Inadequate Guardianship	Substantiated

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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:
Records from the treating hospital were reviewed; however, the record did not reflect a direct inquiry of the emergency room doctors regarding their impressions and findings.

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?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The parents' attorneys did not allow OCDCFS to further interact with their clients once family court was underway by means other than letters, creating a barrier to an ongoing assessment of service needs. The sibling was provided direct placement services and offered additional placement services beyond his 18th birthday, to which he declined.

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 as a result of information uncovered during the fatality investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The surviving sibling's safety was assessed within 24 hours and it was determined a safety plan was necessary. OCDCFS and the family made a safety plan that the sibling would spend the night at a relative's home. As the CPS investigation continued, the safety plan transitioned to a 1017 placement when the sibling was removed on consent on 12/22/22. The sibling remained in this placement for approximately 3 months, at which point he reached age 18 and declined further placement services.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/22/2022	There was not a fact finding	There was not a disposition
Respondent:	063415 Mother Female 34 Year(s)	

Comments:	A Neglect Petition was filed 12/22/22, which referenced the deplorable home conditions and lack of medical care for the now deceased subject child. The mother and grandmother consented to the removal of the sibling and he was placed pursuant to FCA 1017 with a relative, with whom he had a prior positive relationship. Contact was ordered to be supervised between the respondents and surviving sibling. The sibling turned 18 prior to fact finding and disposition. As the sibling did not wish to remain in a formal placement through OCDCFS, and there were no minor children in the household following the passing of the subject child, OCDCFS withdrew their petitions in court on 3/14/23.

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/22/2022	There was not a fact finding	There was not a disposition
Respondent:	063416 Stepfather Male 41 Year(s)	
Comments:	A Neglect Petition was filed 12/22/22, which referenced the deplorable home conditions and lack of medical care for the now deceased subject child. The mother and grandmother consented to the removal of the sibling and he was placed pursuant to FCA 1017 with a relative, with whom he had a prior positive relationship. Contact was ordered to be supervised between the respondents and surviving sibling. The sibling turned 18 prior to fact finding and disposition. As the sibling did not wish to remain in a formal placement through OCDCFS, and there were no minor children in the household following the passing of the subject child, OCDCFS withdrew their petitions in court on 3/14/23.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/22/2022	There was not a fact finding	There was not a disposition
Respondent:	063418 Grandparent Female 63 Year(s)	
Comments:	A Neglect Petition was filed 12/22/22, which referenced the deplorable home conditions and lack of medical care for the now deceased subject child. The mother and grandmother consented to the removal of the sibling and he was placed pursuant to FCA 1017 with a relative, with whom he had a prior positive relationship. Contact was ordered to be supervised between the respondents and surviving sibling. The sibling turned 18 prior to fact finding and disposition. As the sibling did not wish to remain in a formal placement through OCDCFS, and there were no minor children in the household following the passing of the subject child, OCDCFS withdrew their petitions in court on 3/14/23.	

Have any Orders of Protection been issued? Yes	
From: 12/22/2022	**To:** 03/14/2022
Explain: As a result of the Neglect Petitions being filed, contact between the surviving sibling and the respondents was ordered to be supervised. The 1017 resource was approved to provide the supervision. On 3/14/23, the Neglect Petitions were withdrawn.	

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:
Although the sibling was removed as a result of the fatality investigation, he was placed in a direct placement with a relative rather than foster care.

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 sibling was engaged in counseling services by the time he reached age 18 and the services stage was closed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The parents were provided with bereavement services resources; however, following the filing of petitions in family court, the parents' attorneys requested OCDCFS only communicate with their clients via letters. It was unknown if the parents or grandmother engaged in any services.

History Prior to the Fatality

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

In 2015, the family participated in a FAR case with OCDCFS, precipitated by allegations of Inadequate Guardianship against the mother regarding the sibling.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

The 17-year-old sibling (age 16 at the time) and the maternal grandmother received preventive services from a contract agency through OCDCFS, 3/9/21 to 10/21/21. The original reason for case opening surrounded the sibling's academic performance, in that he was not completing virtual schoolwork, as well as the recent loss of his great-grandmother and its subsequent effect on his mental health. The sibling was residing with the maternal grandmother at the time the case opened, and she had custody of him. The service plan included goals around creating a structured household schedule, engaging in mental health services, and completing schoolwork. The closing FASP reflected the family made minimal to no change in their goals. The case record reflected the case was closed due to lack of contact from the family.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

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