NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: BU-15-010 **Prepared by: Buffalo Regional Office**

Issue Date: 3/25/2016

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
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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 17 year(s)
Jurisdiction: Niagara
Gender: Female
Date of Death: 03/07/2015
Initial Date OCFS Notified: 03/08/2015

Presenting Information

The Subject boyfriend (SBF) abducted SC, when she was 14 years old and was pimping her out and using her in a sexual act in exchange for money. The SBF was also drugging SC and providing her with drugs. SC almost died of a drug overdose while with SBF, when she was 15 years old. SC eventually escaped out of SBF home. SM was jailed at that time. SM was released and regained custody of SC. SM had been allowing SC to have regular contact with SBF, despite his history of abducting, drugging and engaging in sexual activity with SC and beating SC on a regular basis. SBF has a history of drug and alcohol abuse and becoming violent. Sometime approximately a week ago, SBF physically beat SC badly, causing bruises to her ribs. On March 6, 2015 SBF found SC possibly overdosed on drugs and deceased at his house. SBF did not call the police and he fled when someone else did call the police.

Executive Summary

This report concerns the death of a 17-year-old child whose family was known to child protective services for many years. The mother had a history of drug abuse, domestic violence and incarceration. The child was sent to live with her grandmother, who was unable to control her. The child was not adequately supervised, and was reportedly using drugs provided by an adult sibling and running away in October 2012. The grandmother reached out to law enforcement and probation and took the child for evaluation and treatment. Another SCR report in November 2012 alleged the child had been abducted and held against her will for weeks by an unrelated male “family friend”, beaten and sexually abused her; the report was unfounded. The child protective services case was closed when safety and risk assessments were not completed accurately, although the child required hospitalization for a drug overdose.

Subsequent reports were made and unfounded against the PGM, the unrelated adult male abductor and the mother regarding the child’s drug use, inadequate guardianship, educational neglect and lack of supervision while the child continued to use drugs and run away. In February 2014, ECDSS worked with law enforcement, sought and obtained custody of the child due to human trafficking concerns, but the child was never picked up and no services case was opened. The report remained open for investigation for 18 months, and many of the case notes were not entered until after the child’s death. The SM regained custody of the child in August 2014, but ECDSS made no home visit. The SM continued to allow the child to stay with the unrelated male, who provided her with drugs, beat her and sexually abused her. On March 6, 2015 the man found the child dead of an apparent drug overdose.

The autopsy report stated that the cause of death was acute mixed drug intoxication, including fentanyl, heroin, cocaine, oxycodone, oxymorphone, hydroxyzine and lorazepam. The manner of death was accident. On June 10, 2015 NCDSS substantiated the allegations of CDAM, IG and DOA/Fatality against SM. SM admitted to permitting SC to leave the home with opiate medication following a dental appointment. SM also allowed SC to associate with SM's husband’s former drug dealer, who is the unrelated male. To date, the unrelated male has not been found or charged.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** 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:
NCDSS substantiated the allegations of CDAM, IG and DOA/Fatality against SM. SM clearly failed to demonstrate an acceptable level of care and supervision and placed SC at risk.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
NCDSS Substantiated the allegations against SM and unfounded the allegations at SBF, due to lack of evidence. The buffalo police nor ECDSS could not find SBF to interview him and the Buffalo police did not want ECDSS to speak to SBF.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	NCDSS did not document any efforts to contact first responders regarding the fatality of SC.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	NCDSS will document all attempts to contact appropriate collaterals on all fatality investigations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/07/2015 **Time of Death:** 01:30 PM

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

County where fatality incident occurred: ERIE

Was 911 or local emergency number called? Yes
Time of Call: 01:40 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was: Unknown if they were impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	17 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Other Household 1	Father	No Role	Male	40 Year(s)
Other Household 2	Other	Alleged Perpetrator	Male	44 Year(s)
Other Household 3	Grandparent	No Role	Female	58 Year(s)

LDSS Response

On March 8, 2015 NCDSS spoke with the source of the report and attempted to speak to the Buffalo Police.

On March 9, 2015 NCDSS spoke with PGM regarding previous concerns for the SC safety. NCDSS also spoke to ECDSS regarding open CPS investigation and interviewing SBF. NCDSS also spoke to the North Tonawanda Police Department, regarding SM and any involvement.

On March 10, 2015 NCDSS completed a home visit with SM. The SM tended not to answer CW's questions, but did state SBF was a friend of the family. She stated that SC was very independent and she didn't know where SC went when she left the home. The SM stated she was aware that SC had smoked marijuana and had used crack cocaine in the past with her paternal side of the family. The SM stated that SC had a dental appointment on March 5, 2015 and was prescribed hydrocodone and another pain medication. When SC got home she took the bottles of prescriptions and left the home. The SM stated the following day she got a call from a man who told her SC had died. NCDSS spoke to the ME's office who stated an autopsy was being done and SC was pronounced dead on March 7, 2015 at 1:30 PM and the last time SC was seen alive was 8:00 AM that day.

On March 19, 2015 ECDSS was told by the Buffalo Police not to interview SBF due to the criminal case.

On April 6, 2015 NCDSS spoke with the Buffalo Police. The police stated the owner of the home called 911 when SC was found. The owner stated that SC dated the SBF. The SC was found in a bedroom with several syringes and it appeared SC had track marks on her hand. The owner of the home admitted to injecting drugs also.

On several occasions the NCDSS left SM phone messages, mailed letters and left notes at her home for contact. The SM did not respond. On April 17, 2015 NCDSS spoke to SM's parole officer and advised that SM was not responding to CW's attempts at contact. The Parole Officer stated SM has not tested positive for any drugs or alcohol.

On April 29, 2015 ECDSS attempted a home visit at the home where SC was found and nobody was home.

On June 5, 2015 NCDSS attempted to contact UB Pediatric Dentistry, but without a release of information, they would not give out any information.

On June 10, 2015 NCDSS substantiated the allegations of CDAM, IG and DOA/Fatality against SM. She admitted to permitting SC to leave the home with opiate medication following a dental appointment. She also allowed SC to associate with her husband's former drug dealer, who is the SBF. The SC was found deceased with syringes in her room and opiates on her person. SM clearly failed to demonstrate an acceptable level of care and placed SC at risk. The allegations of CDAM and DOA/ Fatality against SBF was Unsubstantiated. There was a lack of evidence to implicate SBF, law enforcement and CPS have not located him to interview him.

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: The family resided in Niagara County, but the fatality happened in Erie County.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: The majority of the investigation took place in Erie county.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
024401 - Deceased Child, Female, 17 Yrs	024402 - Mother, Female, 40 Year(s)	Childs Drug / Alcohol Use	Substantiated
024401 - Deceased Child, Female, 17 Yrs	024402 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Substantiated

024401 - Deceased Child, Female, 17 Yrs	024404 - Other - subject's house, Male, 44 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
024401 - Deceased Child, Female, 17 Yrs	024404 - Other - subject's house, Male, 44 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
024401 - Deceased Child, Female, 17 Yrs	024402 - Mother, Female, 40 Year(s)	DOA / Fatality	Substantiated
024401 - Deceased Child, Female, 17 Yrs	024404 - Other - subject's house, Male, 44 Year(s)	DOA / Fatality	Unsubstantiated
024401 - Deceased Child, Female, 17 Yrs	024404 - Other - subject's house, Male, 44 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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?	☐	☒	☐	☐

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	Needed but not Offered	Needed but Unavaliable	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:
The SM only met with NCDSS on one occasion. The SM would not respond to any further attempts to communicate.

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? N/A
Explain:
No SS under the age of eighteen.

Were services provided to parent(s) and other care givers to address any immediate needs related to the

fatality? Yes
Explain:
The SM met with NCDSS once, but then would not engage in the CPS investigation.

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?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/17/2012	6843 - Deceased Child, Female, 15 Years	6841 - Grandparent, Female, 57 Years	Lack of Supervision	Unfounded	Yes
	6843 - Deceased Child, Female, 15 Years	6841 - Grandparent, Female, 57 Years	Inadequate Guardianship	Unfounded	
	6843 - Deceased Child, Female, 15 Years	6841 - Grandparent, Female, 57 Years	Childs Drug / Alcohol Use	Unfounded	

Report Summary:
SC was out of control and PGM could not control her behaviors. The SC was defiant, and had a history of running away, she did what she wanted when she wanted. She was hanging with a very dangerous crowd when she was out unsupervised and she was using drugs and getting high while unsupervised. PGM was aware of all of this but failed to adequately address it so it was ongoing. Referrals were made to address the children's behaviors but PGM failed to follow through. The child had been missing since Ocotber 12, 2012. The SC required a higher level of supervision than grandmother was able to provide . SM had an unknown role.

Determination: Unfounded | **Date of Determination:** 12/28/2012

Basis for Determination:
Child ran away from home and claimed she was abducted. Guardian acted in an appropriate manner, contacting law enforcement. Guardian had reached out to probation prior to child's disappearance. The SC returned home and PGM enrolled her into treatment.

OCFS Review Results:
The closing safety assessment had no safety factors identified however SC had a drug overdose and was hospitalized on December 20, 2012.
The RAP did not identify that children were previously placed outside the home and remained in PGM custody. The RAP

also did not identify that PGM felt threatened, by neighbors and feared for her and her family's safety.

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

Issue:
Investigation Conclusion Safety Assessments

Summary:
The closing safety assessment had no safety factors identified however SC had a drug overdose and was hospitalized on December 20, 2012.

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

Action:
ECDSS will complete all safety assessment accurately and identify all safety concerns.

Issue:
Predetermination/Assessment of Current Safety and Risk

Summary:
The RAP did not identify that children were previously placed outside the home and remained in PGM's custody. The RAP also did not identify that PGM felt threatened, by neighbors and feared for her and her family's safety.

Legal Reference:
18 NYCRR 432.1(aa)

Action:
ECDSS must make sure all risk elements are assessed correctly on the RAPS for all child protective investigations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/09/2012	7121 - Deceased Child, Female, 15 Years	7125 - Mother, Female, 37 Years	Inadequate Guardianship	Unfounded	Yes
	7121 - Deceased Child, Female, 15 Years	7125 - Mother, Female, 37 Years	Sexual Abuse	Unfounded	

Report Summary:
SC was abducted by a neighborhood predator, aided by SC half brother, in October. The SC was held for three weeks. During this time, she was drugged, beaten, and sexually abused. The brother allowed SC phone contact with SM, who is currently incarcerated, on more than one occasion. SC begged SM to get her out of the situation. SM took no action and told no one about what was happening to SC. The PGM who is legally responsible for SC, had been appropriate, filing a missing persons report on the SC, and maintaining close contact with the police.

Determination: Unfounded | **Date of Determination:** 12/12/2012

Basis for Determination:
SC stated that she was being held against her will by her SS and neighbor. During the nearly four week period that she was gone, SC stated that she was drugged, hit and may have been sexually abused, though she had limited memory. SC had been seen medically. SC did test positive for cocaine and marijuana, but had a history of drug use and admitted to using recreationally. SC stated that she had phone contact with SM during the time she was gone. SC told SM that she was being hit, drugged and wanted to go home. SM did not have custody of SC and was not a caregiver, therefore, allegations were unfounded. The Buffalo Police had an open case. The case was open for preventive services.

OCFS Review Results:
The 17-years-old SS, who resided in the home, delivered a baby while the case was open and was never seen or added to the investigation. ECDSS did however add the new born baby to the FSS case and the baby was seen by the case

manager. There was no documentation in the case recorded that ECDSS followed up on the criminal charges pending regarding the allegations. ECDSS did not attempt to interview SM, even though SC was alleging that SM knew where she was and unsubstantiated the allegations against her.

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

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
SM was the subject of the report with allegations of IG and SA against her. ECDSS did not attempt to interview SM or have another local district interview her, since she was outside the county.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
ECDSS must interview and or document attempts to interview all subjects named in SCR reports.

Issue:
A child was born during an open CPS investigation and never added to the report
Summary:
17-years-old SS who resided in the household, had a baby during the CPS investigations. ECCPS was aware SS had a child and did not add that child to the household composition or see that child to assess for safety. ECDSS did however add the new born baby to the FSS case and the baby was seen by the case manager.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(e)
Action:
ECDSS must add all children born during a CPS investigation to the household composition and assess safety on all children residing in the home.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ECDSS did not document any follow up collateral contact with the police department regarding criminal allegations.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ECDSS will make appropriate and relevant collateral contacts on all Child Protection Investigations.

Issue:
Appropriateness of allegation determination
Summary:
ECDSS unsubstantiated the allegations against SM, without interviewing her. SC disclosed during the MDI that while being held against her will, she spoke to and asked SM for help. The SM took no action . ECDSS did not document any follow up regarding criminal case.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
ECDSS must make sure that all child protective investigations thoroughly assess the circumstances and conditions surrounding all allegations contained in SCR reports or discovered in an investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/19/2012	7131 - Deceased Child, Female, 15 Years	7132 - Grandparent, Female, 57 Years	Childs Drug / Alcohol Use	Unfounded	Yes
	7131 - Deceased Child, Female, 15 Years	7132 - Grandparent, Female, 57 Years	Inadequate Guardianship	Unfounded	

Report Summary:
SC had a history of drug use. PGM was aware, but failed to intervene as a result, on December 18, 2012 SC was found unresponsive on the sidewalk. SC was high on cocaine, zanax and marijuana.

Determination: Unfounded **Date of Determination:** 02/21/2013

Basis for Determination:
SC left school without permission with some other students and used drugs. SC used enough drugs to render her unresponsive and SC was hospitalized. PGM had no idea that SC was going to leave school without permission and use drugs. SC has had behavior issues and is on probation. Family has been linked to services and attend an drug and alcohol appointment.

OCFS Review Results:
The family was linked with services and SC had begun drug treatment. The 17-year-old SS was named on the report and living in the home, with her new born child. ECDSS reported SS as added in error and removed her from the case, without interviewing SS and assessing safety of her and her son. ECDSS did however add the new born baby to the FSS case and the baby was seen by the case manager. The seven day and closing safety assessment had no safety factors identified however SC had a drug overdose and was hospitalized on December 20, 2012.

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

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

Summary:
The 17-year-old SS, who was named on the report was residing in the home with her newborn son and was not interviewed. Neither child was assessed for safety and the SS role was inappropriately changed to reported in Error in CONNECTIONS. ECDSS Preventive Services case notes document SS in the home. ECDSS did however add the new born baby to the FSS case and the baby was seen by the case manager.

Legal Reference:
18 NYCRR 432.1 (b)(3)(ii)(a)

Action:
ECDSS must interview and assess safety for all children named on an SCR report. ECDSS needs to document sufficient attempts to interview all children named on any SCR report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/30/2013	7145 - Deceased Child, Female, 15 Years	7141 - Grandparent, Female, 58 Years	Childs Drug / Alcohol Use	Unfounded	No
	7145 - Deceased Child, Female, 15 Years	7141 - Grandparent, Female, 58 Years	Inadequate Guardianship	Unfounded	
	7145 - Deceased Child, Female, 15 Years	7143 - Aunt/Uncle, Female, 33 Years	Inadequate Guardianship	Unfounded	

Report Summary:
PGM could not control SC. SC was hanging around a man 38 years old alone and unattended and getting into trouble. The man controlled SC. The man provided SC with drugs to use and PGM was aware. The man instigated SC to fight and cut her aunt with a razor blade. The Aunt punched SC in the face. It was unknown if SC sustained any injuries. The man had guns and was involved in a shoot out. In the past, the man took SC against her will.

Determination: Unfounded	**Date of Determination:** 06/18/2013

Basis for Determination:
No evidence was found to substantiate the allegations against PDM and PA. SC was a 16 year old run-away with a history of behavior problems. Although there was a physical altercation between PA and SC, it appeared that the incident was initiated by SC and PA only defended herself. SC had been on the run and CW was unable to see her. PGM had, filed a warrant for SC but, to date, SC had not been located. All other children in the home were safe and receiving adequate care.

OCFS Review Results:
ECDSS spoke to PGM several times who denied having contact with SC. ECDSS did speak to the father of the PA's children, who did not have concerns for his children's safety. On June 17, 2013 ECDSS did attempt a home visit at SBF's home to locate SC. ECDSS was informed he had moved out. On June 19, 2013 ECDSS did speak to the Buffalo Police, who confirmed there was an open case involving SC and they have regular contact with PGM.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/09/2014	7165 - Deceased Child, Female, 16 Years	7164 - Adult Sibling, Male, 20 Years	Childs Drug / Alcohol Use	Unfounded	Yes
	7165 - Deceased Child, Female, 16 Years	7161 - Grandparent, Female, 59 Years	Educational Neglect	Unfounded	
	7165 - Deceased Child, Female, 16 Years	7164 - Adult Sibling, Male, 20 Years	Inadequate Guardianship	Unfounded	
	7165 - Deceased Child, Female, 16 Years	7161 - Grandparent, Female, 59 Years	Inadequate Guardianship	Unfounded	
	7165 - Deceased Child, Female, 16 Years	7161 - Grandparent, Female, 59 Years	Lack of Supervision	Unfounded	

Report Summary:
SC age 16 years old had a history of running away with her 40 year old boyfriend. One time, SC ran away for six months and her whereabouts were in question because it was stated that she was being held against her will. SC resided with her PGM and she came and went as she pleased, because she was not being supervised. PGM was unable to control SC's behavior and she could not make her go to school so the SC hadn't been to school for at least a month. These excessive absences must have had a negative impact on SC studies with the PGM knowledge. SC's 20-year-old brother had supplied her with drugs. SC almost died last year due to a drug overdose.

Determination: Unfounded	**Date of Determination:** 07/21/2015

Basis for Determination:
PGM was attempting to care for SC. Due to SC's behaviors, PGM was unable to care for her. The department filed a neglect petition due to direct threats from the trafficker and PGM's safety. (FBI involvement and involvement with the International Institute due to human trafficking concerns for SC) SC was a runaway for most of ECDSS involvement. In August of 2014, SC was returned to SM's custody and petition was dismissed. SC has since passed away from an alleged drug overdose while she was with the person who may have been responsible for the human trafficking case. 20-year-old

SS denied allegations and has been incarcerated for other allegations.

OCFS Review Results:

ECDSS spoke with law enforcement, who asked CPS not to contact alleged subject or child, due to criminal investigation in January 2014. On April 10, 2014 law enforcement informed CPS that they believe they located SC and would be picking her up. CPS did not follow up with law enforcement and no further work was done on the investigation until after SC's death. On February 24, 2014 ECDSS obtained custody of SC and ECDSS did not open a services case. Several progress notes in the case recorded was not documented until after SC's death.

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

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

ECDSS did not complete an appropriate investigation. Police requested ECDSS not make contact with SC, until they located SC. ECDSS did not follow up despite being notified of police locating SC in April 2014. No further case activity until after SC's death despite neglect petition and remand of SC in February 2014. The report was open for 18 months, many case notes not completed until after death.

Legal Reference:

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:

ECDSS must complete appropriate investigations for all SCR reports, including contact with children and parents, completing accurate safety and risk assessments, documenting case activity and taking appropriate actions to protect children and provide services.

Issue:

Adequacy of face-to-face contacts with the child and/or child’s parents or guardians

Summary:

During the investigation ECDSS did not make appropriate contact with family member's including PGM,SM and law enforcement about SC's whereabouts. The SM obtained custody of SC in August 2014 and ECDSS did not attempt a home visit or assess the SC's safety.

Legal Reference:

18 NYCRR 432.1 (b)(3)(ii)(a)

Action:

ECDSS must assess safety for all children named on the report and in the home and document all attempts to assess safety.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

ECDSS did not close the child protection investigation for eighteen months. The case record did not contain any documentation for April 10, 2014 to January 3, 2015.

Legal Reference:

18 NYCRR 428.5(a) and (c)

Action:

ECDSS must determine SCR reports within 60 days of receipt of the report. The case documentation must be completed contemporaneously with case events.

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

SM has IND reports from 1996 for IG, due to DV in the home and SF abusing drugs. In 2007 SP were IND for IG and PDAM. The SP had a drug problem and were not compliant with treatment and SM overdosed. ECDSS opened up a Preventive Services case. In 2008 SM was IND for IG, PDAM and other. SM had an altercation with her sister in front of the children and tried to drown her sister. The SM was also taking son's medication. ECDSS filed a neglect petition in Family Court and Children were placed with PGM. The SM was named in three UNS SCR reports in 2006, 2010 and 2011 with allegations of LOS, IG, CDAM, CHTS and LBW'S.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Services Open at the Time of the Fatality

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	ECDSS did not open a services case until March 13, 2015 although a neglect petition was filed and SC placed in ECDSS custody in February 2014. ECDSS did not complete any progress notes in the services case.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ECDSS must provide timely and accurate case documentations for all services cases.
Issue:	Timeliness of completion of FASP
Summary:	ECDSS did not complete any FASPS for the services case opened March 13, 2015 and closed May 22, 2015.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ECDSS must complete all required FASP's in a timely fashion for all open services case.

Preventive Services History

ECDSS had a preventive services case with the family from April 12, 2011 to October 30, 2013. Services were put in place when SM and sibling brother were arrested for weapon charges and child endangerment. The 12-year-old SC and 15-year-old SS were placed in 1017 custody with PGM. PGM was awarded article 6 custody of SC on August 11, 2012. Services ended when SS turned eighteen years old.

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?	☐	☒	☐	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

ECDSS filed a neglect petition in Erie county Family Court against SM with respect to SC and SS and were placed in 1017 custody with PGM on April 12, 2011. PGM was awarded article 6 custody of SC on August 11, 2012. ECDSS then filed a neglect petition against PGM on February 24, 2014 and SC was remanded into the custody of ECDSS. ECDSS never located the child. Erie County Family Court dismissed the neglect petition against PGM on June 10, 2014. The SM then obtained custody of SC in August 2014, from Erie County Family Court.

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 - 7 PINS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/25/2014	There was not a fact finding	Petition Dismissed
Respondent:	None	
Comments:	ECDSS filed a PINS petition and a run away warrant on SC. ECDSS never located the SC and the peitition was dismissed on June 22, 2014.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/24/2014	There was not a fact finding	Petition Dismissed
Respondent:	024581 Grandparent Female 58 Year(s)	
Comments:	On June 10, 2014 ECDSS still had not located the SC and the petition was withdrawn.	

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