Child Fatality Report

Report Identification Number: RO-17-012

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

Issue Date: Oct 20, 2017

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		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 15 year(s)
Jurisdiction: Steuben
Gender: Female
Date of Death: 04/14/2017
Initial Date OCFS Notified: 04/19/2017

Presenting Information

On 4/19/17, a completed OCFS 7065 form was received from Steuben County Department of Social Services (SCDSS) regarding the death of SC, who was involved in an open preventive services case. The form indicated on 4/14/17 at approximately 6:00PM, SC was a passenger in an SUV that was involved in a motor vehicle accident. The vehicle struck a culvert and a tree, which caused the SUV to flip over. SC was pronounced dead at the scene, and an LE investigation into the accident was on-going.

Executive Summary

This fatality report concerns the death of a 15-year-old female (SC) that occurred on 4/14/17 in Chemung County. A completed 7065 form was submitted to OCFS on 4/19/17. At the time of SC's death, SC and BF were engaged in a voluntary preventive service case through Steuben County Department of Social Services (SCDSS). SCDSS gathered the facts regarding the circumstances surrounding SC's death. The final autopsy report was issued and the cause of death noted as "severe blunt trauma, secondary to a motor vehicle collision (passenger)", and manner of death was accidental.

At the time of the fatality, the SC resided with BM, BM's husband (PS), two male step-siblings (ages 14 and 18, unrelated to SC). BM had recently regained custody of SC, and SC had moved into BM's home. Previously, from birth to 15 years, SC resided with BF in Steuben County. The preventive service case was opened as a self-referral by BF, due to SC's ungovernable behaviors and on-going mental health concerns. The manner of SC's death was not found to be suspicious in nature, therefore an SCR report was not made listing her as a maltreated child.

SCDSS learned of SC's death from a news article. There was nothing noted in the case record as to why there was a delay in notifying OCFS of the death. From the time SCDSS was notified of SC's death to the time of this writing, SCDSS had completed interviews with BM, BF, and other adults in the households, as well as spoke with several collateral contacts, including the ME, LE, and agency personnel. SCDSS gathered sufficient information surrounding SC's death, and appropriate services were offered to the family.

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Explain:
SC resided with BM, BM's husband, and BM's two children, ages 18 and 14. SCDSS did not observe or interview the 14 y/o child, nor assess his risk/safety.

Determination:

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

Explain:
SCDSS gathered information surrounding SC's death from family members and various collateral contacts. The casework activity was commensurate with the case circumstances.

Was the decision to close the case appropriate? N/A
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:
SC's death was investigated fully by SCDSS. The services case was closed.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/14/2017 **Time of Death:** 05:55 PM

County where fatality incident occurred: Chemung
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
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? Yes
Is the caretaker listed in the Household Composition? No
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	No Role	Female	15 Year(s)
Deceased Child's Household	Mother	No Role	Female	40 Year(s)
Deceased Child's Household	Stepfather	No Role	Male	39 Year(s)
Other Household 1	Aunt/Uncle	No Role	Female	68 Year(s)
Other Household 1	Father	No Role	Male	47 Year(s)

LDSS Response

On 4/15/17, SCDSS was notified SC was involved in a motor vehicle accident the previous evening at approximately 6PM, and had died at the scene; the accident took place in Chemung County. At the time of SC's death, SCDSS had an open preventive services case which involved BF and SC. The preventive services caseworker immediately contacted their supervisor upon hearing of SC's death. The following day, SCDSS attempted a home visit to offer BF services, but BF was not at home. On this same date, SCDSS conducted a home visit to BM's home to offer condolences and services, as well as begin gathering information surrounding what lead to SC's death. BM declined the offer of services, and the caseworkers were informed SC was involved in a high-speed one-vehicle accident around 6PM on 4/14/17. BM's husband and MGM were also present during this home visit. At this point, SCDSS did not ask any questions surrounding possible SS or any other children residing in the household.

On 4/20/17, SCDSS met with BF in his home, and offered him appropriate services. BF informed SCDSS he had already made an initial call for mental health/grief counseling. SCDSS provided BF with additional information regarding services that were available in his community. SCDSS did not ask any questions surrounding possible SS.

On 4/25/17, SCDSS attended a CFRT meeting at the Chemung County Child Advocacy Center; LE was also in attendance. Details surrounding the accident and SC's death were revealed by LE at this meeting. It was determined there were seven individuals in the vehicle: the adult driver and six children, ages 2 weeks to 15 years old, including SC; they were headed back from a local park. SC was the only passenger that died due to the accident, and she was pronounced deceased at the scene. It was determined the driver of the vehicle was not considered a personal legally responsible for SC, but an SCR report was made to Chemung County Department of Social Services regarding the driver and her children that were additional passengers in the vehicle. LE established the SUV was traveling at a high rate of speed (70-75 miles per hour in a 30 mile per hour zone) and the driver lost control of the vehicle, which caused the SUV to veer off the road, hit a culvert, a tree, and then flip multiple times. LE discovered the driver was following behind her ex-boyfriend, who was also driving at a high rate of speed in his own car. It was revealed SC was not wearing a seat belt at the time of the accident, and the driver of the vehicle only had a Learner's Permit. There was no evidence the driver of the SUV was under the influence of alcohol or drugs. It was not documented if SC had ridden with the driver previously, or if any criminal charges were going to be pursued against the driver.

At the time of this writing, preventive services remained open, although no other children were listed on the case. SCDSS did not observe or interview the 14-year-old step-sibling that resided with SC, but did complete home visits and spoke with all adults in the households. Review of the family's history revealed SC had 5 SS, some of which were adults at the time of

SC's death. SCDSS did not document they explored if SC had any minor SS, or whether they had regular contact with SC. SCDSS spoke with collateral contacts and obtained the Death Certificate and final autopsy. The cause of death was noted as "severe blunt trauma, secondary to a motor vehicle collision (passenger)", and manner of death was accidental.

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 reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Steuben County does not have an OCFS approved Child Fatality Review Team; however, this fatality was reviewed by the Chemung County Child Fatality Review Team, since that is the county where the death occurred.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☒	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
A 14 y/o step-sibling resided in SC's home, and was never assessed or interviewed by SCDSS, but his school was contacted to see if they had any concerns regarding his well-being. Progress notes were not entered contemporaneously.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☐	☒	☐
At 7 days?	☐	☐	☒	☐

At 30 days?	☐	☐	☒	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☒	☐	☐	☐
Explain: There was a 14-year-old step-sibling that resided in BM's home. He was not observed or interviewed.				
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: There was a 14-year-old step-sibling who resided in the same home as SC. This child was not noted to have been observed or interviewed.				

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: A full risk assessment was not completed, and service needs were not fully explored, as the 14-year-old surviving step-sibling was never seen/interviewed.				

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:
SC resided with BM, BM's husband, and BM's two children, ages 18 and 14. SCDSS did not observe or interview the 14 y/o child.

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:
SCDSS offered the family appropriate services, but they declined.

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? No
Explain:
SCDSS did not establish whether or not there were SS to be considered for services. The step-sibling was not observed/interviewed. SCDSS spoke with the SS's school to assess if they had any concerns regarding his well-being, which they denied.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Counseling/grief services were offered to the family after SC's death.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	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)
11/04/2016	Deceased Child, Female, 15 Months	Aunt/Uncle, Male, 59 Years	Sexual Abuse	Unfounded	Yes
	Deceased Child, Female, 15 Months	Aunt/Uncle, Male, 59 Years	Inadequate Guardianship	Unfounded	

Report Summary:
This report was received with concerns SC was sexually abused by her PU from age 6 until age 12. The abuse would occur when PU would regularly visit BF's home to go swimming. The roles of BF, MA, and BM were unknown.

Determination: Unfounded
Date of Determination: 03/15/2017

Basis for Determination:
Through home visits, interviews, and collateral contacts, SCDSS found no evidence to support the allegations and appropriately unfounded the report. Interviews revealed inconsistencies in statements made by SC, and it was discovered SC did not have contact with PU during the time she alleged she was abused. Additional concerns were addressed appropriately throughout the investigation.

OCFS Review Results:
The investigation was complete and determination appropriate; however, notes were not entered contemporaneously in Connections throughout the investigation, and the Notices of Existence were not mailed until 3/2/17.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Many progress notes were not entered into Connections until over one month after the event date.
Legal Reference:
18 NYCRR 428.5

Action:
SCDSS will enter progress notes into Connections contemporaneously as events occur.

Issue:
Failure to provide notice of report

Summary:
SCDSS did not send letters of existence until 3/2/17.

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

Action:
SCDSS will notify the subjects and other persons named (except children under age 18) in a report in writing no later than seven days after receipt of the oral report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/02/2016	Deceased Child, Female, 14 Years	Father, Male, 46 Years	Choking / Twisting / Shaking	Unfounded	Yes
	Deceased Child, Female, 14 Years	Father, Male, 46 Years	Inadequate Guardianship	Unfounded	

Report Summary:
This report was received with concerns BF was physically aggressive toward SC, then age 14, and on 3/1/16 he grabbed SC by her sweatshirt and threw her into a wall. Further, the report alleged BF choked SC and then threw her on the couch; BF had a history of physical aggression toward SC.

Determination: Unfounded **Date of Determination:** 05/16/2016

Basis for Determination:
Through home visits, interviews, and collateral contacts, SCDSS found no evidence to support the allegations and appropriately unfounded the report. SC revealed inconsistent information during interviews, and SCDSS observed no marks or bruises on the child. Additional services were offered to the family but declined. The family remained engaged in preventive services at the close of the investigation.

OCFS Review Results:
The investigation was complete and the determination was appropriate.; however, many notes were not entered contemporaneously in Connections throughout the investigation.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
Many progress notes were not entered into Connections until over one month after the event date.

Legal Reference:
18 NYCRR 428.5

Action:
SCDSS will enter progress notes into Connections contemporaneously as events occur.

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

11/24/2015	Deceased Child, Female, 14 Years	Father, Male, 45 Years	Educational Neglect	Unfounded	Yes
	Deceased Child, Female, 14 Years	Father, Male, 45 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Female, 14 Years	Father, Male, 45 Years	Emotional Neglect	Unfounded	
	Deceased Child, Female, 14 Years	Father, Male, 45 Years	Lack of Medical Care	Unfounded	

Report Summary:
This report was received with concerns SC, then age 14, missed school often, had frequent suspensions, and was exhibiting untreated mental health issues. Further, the report alleged BF was aware of the concerns and failed to intervene.

Determination: Unfounded | **Date of Determination:** 02/22/2016

Basis for Determination:
Through home visits, interviews, and collateral contacts, SCDSS found no evidence to support the allegations and appropriately unfounded the report. As a response to this investigation, BF requested preventive services, and SCDSS assisted with opening the case. The preventive services case remained open at the time of this writing.

OCFS Review Results:
The investigation was complete and the determination was appropriate. Appropriate services were offered and accepted by BF. Many progress notes were not entered contemporaneously in Connections throughout the investigation.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
Many progress notes were not entered into Connections until over one month after the event date.

Legal Reference:
18 NYCRR 428.5

Action:
SCDSS will enter progress notes into Connections contemporaneously as events occur.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/24/2015	Deceased Child, Female, 13 Years	Father, Male, 45 Years	Inadequate Guardianship	Unfounded	Yes
	Deceased Child, Female, 13 Years	Father, Male, 45 Years	Lack of Medical Care	Unfounded	

Report Summary:
This report was received with concerns SC, then age 13, was suffering from untreated mental health issues, was exhibiting cutting behaviors, and needed to be re-engaged in treatment. Further concerns BF was abusing alcohol and verbally abusing SC.

Determination: Unfounded | **Date of Determination:** 04/30/2015

Basis for Determination:
Through home visits, interviews, and collateral contacts, SCDSS appropriately unfounded the report. SCDSS assisted BF with getting SC engaged back into mental health services prior to the case closing. SCDSS did not find evidence that BF was neglecting SC's mental health needs.

OCFS Review Results:
The investigation was complete and the determination was appropriate; however, many notes were not entered contemporaneously throughout the investigation.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
Many progress notes were not entered into Connections until over one month after the event date.

Legal Reference:
18 NYCRR 428.5

Action:
SCDSS will enter progress notes into Connections contemporaneously as events occur.

[redacted]

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

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

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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: 12/03/2015

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

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
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:
BM self-referred for preventive services due to SC's ungovernable behaviors and on-going mental health concerns.

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:	The majority of the progress notes in the services case were not entered into Connections until one year or later after the event date.
Legal Reference:	18 NYCRR 428.5
Action:	SCDSS will enter progress notes into Connections contemporaneously as events occur.
Issue:	Failure to offer services
Summary:	A 14-year-old step-sibling resided in the home of SC. SCDSS did not assess if there was any risk associated with this child, or if there were any service needs for him or other family members.
Legal Reference:	SSL §424(10);18 NYCRR 432.3(p)
Action:	SCDSS will assess safety/risk of all children residing in a household and offer services as appropriate.

Preventive Services History

11/18/05-7/19/06: Preventive Services/PINS case opened regarding SC's half-sister. BF filed PINS petition regarding the child due to ungovernable behaviors. The case was closed per BF's request.

3/3/14-2/24/15: Preventive Services/PINS case opened regarding SC. BF self-referred due to SC's ungovernable behaviors at home. The case was closed per BF's request.

12/3/15: BF again self-referred for Preventive Services due to SC's behaviors and mental health concerns/needs. The case had been closed at the time of this writing.

Required Action(s)

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

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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

Additional Local District Comments

The unfortunate passing of this child was a result of an automobile accident. Her parents were not driving the vehicle, a parent to the child's friend she was spending the day with was the driver of the vehicle. Albeit the citations, it is necessary for SCDSS to confirm that the passing of this child was not the result of neglect/abuse issues on the part of the parents nor is the passing of the child in this case a direct result of the action or inaction of the SCDSS.

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