Child Fatality Report

Report Identification Number: SY-21-022

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

Issue Date: Nov 15, 2021

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☒ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 05/15/2021
Initial Date OCFS Notified: 05/16/2021

Presenting Information

An SCR report alleged that on 5/15/21, the mother woke up in the morning and gave the 4-month-old subject infant a bottle. The mother fell asleep and when she woke up she found the infant unresponsive. The mother pushed the infant to the hospital in a stroller and they arrived at 8:50 AM. The role of the siblings, ages 3, 6, 7, 10, 16 and 18 was unknown.

Executive Summary

On 5/16/21, the Oneida County Department of Social Services (OCDSS) received an SCR report regarding the death of the 4-month-old male infant. At the time of the infant's death, he resided with his mother and five siblings ages 16, 10, 7, 6, and 3. There was a 12-year-old sibling who resided with her paternal grandmother, who had Article 6 custody of her, and she visited the home often. The father of the subject infant and three youngest siblings had regular visitation with the children. The 16 and 10-year-old siblings visited their fathers regularly.

OCDSS had an open CPS Services Case at the time of the infant's death, which opened on 1/7/21, due to the 16-year-old sibling's behavioral issues and truancy from school. The mother had a difficult time managing the 16-year-old sibling's behavior, there was a history of educational neglect for the school-aged siblings, and the mother had a history of marijuana use with a positive toxicology at the birth of the subject infant. The mother did not cooperate with the services she was referred to, therefore OCDSS had filed an Article 10 Neglect Petition on 3/26/21. The petition was pending in Family Court at the time of the infant's death. During the open services case safe sleep education was provided to the mother, a portable crib was observed in the home and the mother had the necessary infant supplies.

OCDSS conducted a joint investigation into the infant's death with law enforcement, and they learned that between 8:00 and 8:30 AM on 5/15/21, the mother awoke to find the infant unresponsive. The mother placed the infant in a stroller and walked with the five youngest siblings to a nearby hospital. Attempts to resuscitate the infant were unsuccessful and the infant was pronounced deceased at the hospital at 9:51 AM.

The mother did not cooperate with the fatality investigation and she declined to speak to OCDSS about the incident until 8/18/21. The siblings were interviewed at family member's homes and they disclosed that they were left in the care of the 12-year-old sibling on the night prior to the incident. Due to the pending Neglect Petition, concerns for supervision, the mother's marijuana use, the siblings being behind on well-child visits, the 16-year-old sibling's location being unknown, and the preliminary autopsy examination finding a possible healing rib fracture, an Abuse Petition was filed against the mother on 6/4/21. At the initial court appearance, the three youngest siblings were placed with the father and the paternal grandmother and the 10-year-old sibling was placed with his father under Article 1017. The 16-year-old sibling was temporarily placed in Foster Care for a few days until he was located and placed in the custody of his father under Article 1017. An order of protection was issued barring the mother from unsupervised contact with the three youngest siblings.

The final autopsy report revealed the cause of death was bacterial sepsis due to community acquired pneumonia and the manner of death was natural. There was congenital bone bridging found between the 7th and 8th ribs, which was determined not to be a fracture. The autopsy report stated that the infant was brought to the emergency department by the mother, unresponsive and not breathing. The mother reported that the infant woke up around 5:30 AM crying, and she believed he was hungry. She bottle fed him, burped him and placed him on his back in a bassinet. She awoke again between 8:00 and 8:30 AM and found him unresponsive. She placed him in a stroller and ran to the hospital nearby with

the siblings. The law enforcement investigation remained open and no charges had been filed at the time of this writing.

OCDSS provided the mother with information on bereavement services for herself and the siblings and the mother was referred for a substance abuse evaluation and mental health evaluation. The fatality investigation and the CPS Services Case remained open at the time this report was written.

PIP Requirement
For citations identified in historical cases and the open services case, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS 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

Explain:
The investigation had not yet been determined at the time this report was written.

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:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

Child Fatality Report

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/15/2021 **Time of Death:** 09:51 AM

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

County where fatality incident occurred: Oneida
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? N/A
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
At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☒ Asleep ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Male	16 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Other Household 1	Sibling	No Role	Female	12 Year(s)
Other Household 2	Other Adult - 16yo Sibling's Father	No Role	Male	40 Year(s)
Other Household 3	Other Adult - 10yo Sibling's Father	No Role	Male	36 Year(s)
Other Household 4	Father	No Role	Male	29 Year(s)
Other Household 5	Adult Sibling	No Role	Male	18 Year(s)

LDSS Response

OCDSS began their investigation into the infant's death upon receipt of the SCR report on 5/16/21. They reviewed SCR history, notified the DA's office of the infant's death and they spoke to the source of the report, law enforcement, medical examiner, pediatrician, preventive services case manager, and several family members. OCDSS interviewed the mother, father, siblings, and the fathers of the siblings.

The siblings reported that the mother often left the younger children in the care of the older siblings and the siblings often cared for the infant and fed him bottles. On 5/14/21 the 12-year-old sibling slept at the mother's home. The mother left the five youngest children in her care, and the mother was gone for an unknown period of time. The 12-year-old sibling said she fed the infant a bottle around 8:00 PM and she placed him to sleep in the mother's bed. The 7, 6, and 3-year-old siblings also slept in the mother's bed. Around 5:00-6:00 AM the 7-year-old sibling awoke to the infant crying and she saw that the mother was home and sleeping in the bed. The 7-year-old sibling went into the living room and notified the 12-year-old sibling that the infant was crying. The 12-year-old sibling told her to wake the mother and let her know that the infant needed a bottle. The 12-year-old sibling then went back to sleep. The 7-year-old sibling made a bottle and she propped it up for the infant using a baby blanket, as she had done before. She then fell back to sleep in the mother's bed. Around 8:00 AM the siblings were awoken by the mother who was upset, and they saw the infant's head was slumped over and there was white stuff coming out of his nose. The mother's cell phone battery was dead, and she could not find a charger, so the mother dressed the infant and they all walked to the hospital.

The mother stated that she returned home on 5/14/21 between 10:30 and 11:00 PM. Contradictory to the sibling's statements, the mother reported that she gave the infant a bottle and placed him in his portable crib to sleep. She woke up during the night to give him a bottle and laid him in bed with her at that time. When she woke up in the morning the infant was unresponsive, so she woke the siblings, and they took the infant to the hospital. The mother denied that the infant was coughing or sick prior to his death. The mother said she did not plan to have the infant vaccinated, so she had not taken him for any well child visits since birth.

The father reported that he last saw the infant on 5/13/21 and he appeared to be healthy at that time. The father's home was assessed to be safe for the three youngest siblings. The father of the 10-year-old sibling reported having no knowledge of the infant's death and said he was previously unaware of the concerns for the sibling's attendance and overdue well child visits. His home was assessed to be safe for the sibling. The father of the 16-year-old sibling had no knowledge of the incident and his home was assessed to be safe for the sibling.

Law enforcement reported that they were called to the hospital on the morning of 5/15/21, due to family members fighting in the parking lot. When they arrived, they learned that the mother brought the infant to the hospital, where he was pronounced deceased and they opened an investigation. Upon arrival to the home, law enforcement observed the portable crib to contain bags of items and it did not appear the infant had slept in it. The mother only allowed law enforcement to interview her for 3 minutes, and during this time she reported that she woke up around 5:00 AM to feed the infant, then she went back to sleep. Around 8:00 AM she woke up and noticed the infant was not touching her like he normally did so she poked at him. When the infant did not respond she put a shirt on him and brought the infant and siblings to the hospital. Pediatrician records showed that the infant had not been seen since birth.

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 reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The case was submitted to the Child Fatality Review Team for review.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058578 - Deceased Child, Male, 4 Mons	058579 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Pending
058578 - Deceased Child, Male, 4 Mons	058579 - Mother, Female, 36 Year(s)	DOA / Fatality	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

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 RAP had not yet been completed in Connections; however, risk was adequately assessed and a petition was filed to obtain court ordered services.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The 16, 10, 7, 6 and 3-year-old siblings were removed and placed with relatives under Article 1017.

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:**
06/04/2021	There was not a fact finding	There was not a disposition
Respondent:	058579 Mother Female 36 Year(s)	
Comments:	An Abuse Petition was filed against the mother on 6/4/21 regarding the siblings. The 16, 10, 7, 6 and 3-year-old siblings were removed and placed in the custody of relatives under Article 1017. The Petition was pending in Family Court at the time this report was written.	

Have any Orders of Protection been issued? Yes	
From: 06/04/2021	**To:** Unknown
Explain: A temporary order of protection was issued barring the mother from unsupervised contact with the 7, 6, and 3-year-old siblings.	

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The siblings were referred for bereavement services and they were placed with relatives following the infant's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents declined bereavement services.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☒ Used illicit drugs

Infant was born:

☒ Drug exposed
☐ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/13/2021	Sibling, Male, 16 Years	Mother, Female, 36 Years	Educational Neglect	Substantiated	No
	Sibling, Male, 9 Years	Mother, Female, 36 Years	Educational Neglect	Substantiated	

Sibling, Female, 7 Years	Mother, Female, 36 Years	Educational Neglect	Substantiated
Sibling, Male, 6 Years	Mother, Female, 36 Years	Educational Neglect	Substantiated
Sibling, Male, 0 Days	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 0 Days	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
Two SCR reports were received which alleged the mother gave birth to the subject infant on 1/13/21 and both the mother and subject infant tested positive for marijuana. The role of the siblings was unknown.

Report Determination: Indicated | **Date of Determination:** 04/09/2021

Basis for Determination:
There was a lack of credible evidence that the mother's marijuana use during pregnancy had a negative effect on the subject infant. The infant had no withdrawal symptoms or medical complications and the mother appeared to be sober at all casework contacts. Allegations of Educational Neglect were added and substantiated against the mother. The siblings missed an extensive amount of school and they were not doing well academically. Additionally, the then 5-year-old sibling was not enrolled in school as required. The mother had a history of educational neglect and she did not cooperate with diversion services that began in January 2021. An Article 10 Neglect Petition was filed.

OCFS Review Results:
Home visits were conducted and the home was assessed to be safe. The mother and siblings were interviewed and Notice of Existence was provided to the required adults. Safety Assessments and the RAP were competed timely and accurately. Safe sleep education was provided to the mother and a safe sleep environment was observed. A Plan of Safe Care was completed and unable to be monitored due to the mother's lack of cooperation. Relevant collaterals were contacted and a Neglect Petition was filed to obtain court ordered services.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/30/2020	Sibling, Male, 15 Years	Mother, Female, 35 Years	Educational Neglect	Substantiated	No

Report Summary:
An SCR report alleged the then 15-year-old sibling had a history of excessive absences. The sibling had not participated in online school resulting in 16 unexcused absences. The mother was aware and failed to ensure he participated with his academics. As a result, the sibling was falling behind academically.

Report Determination: Indicated | **Date of Determination:** 01/15/2021

Basis for Determination:
The sibling did not log in for online schooling at all since the school year started. The sibling was staying at family members' homes the majority of the time and the mother failed to ensure the sibling attended school. The mother had a history of educational neglect and the mother was advised to contact probation if the problem continued. The mother did not follow through with contacting probation and she stated her high risk pregnancy with the subject infant was the cause. The mother tested positive for marijuana during prenatal visits and OCDSS addressed the concern. The mother denied using marijuana while caring for the siblings and she appeared sober during all casework contacts.

OCFS Review Results:
Home visits were conducted and the home was assessed to be safe. The mother and siblings were interviewed and Notice of Existence was provided to the required adults. Safety Assessments and the RAP were completed timely and

accurately. Relevant collaterals were contacted and the mother and sibling were referred for the necessary diversion services. The mother agreed to work with diversion services and the case was opened for preventive services.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/06/2020	Sibling, Male, 15 Years	Mother, Female, 35 Years	Educational Neglect	Substantiated	No
	Sibling, Male, 15 Years	Mother, Female, 35 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 15 Years	Mother, Female, 35 Years	Lack of Medical Care	Substantiated	

Report Summary:
An SCR report alleged the then 15-year-old sibling had an ongoing history of truancy and failing academically. The school closed due to the COVID-19 pandemic and the sibling had not done any school work since that date and he was failing all of his classes. There were calls and letters sent to the mother, who was aware of the concerns, but she was either unwilling or unable to ensure the sibling completed his school work. The mother did not have a working phone number and service providers were unable to reach the family. The sibling had very concerning behavioral issues and providers made referrals for mental health care and the mother did not comply with referrals.

Report Determination: Indicated **Date of Determination:** 07/14/2020

Basis for Determination:
There was credible evidence gathered that the mother was aware that the then 15-year-old sibling was not attending school and he was failing his classes. The sibling was leaving the home for days at a time without the mother's permission. The mother was unable to control or manage the sibling's behavior and the mother expressed that she was unable to provide 24/7 supervision of the sibling since she had other children to care for. The mother also failed to follow through with mental health referrals for the sibling. The mother was difficult to contact since she had no working phone and she requested to close her Preventive Services Case.

OCFS Review Results:
OCDSS assessed the home to be safe and they interviewed the mother, father, siblings and siblings' fathers. Safety Assessments and the RAP were completed timely and accurately. Notice of Existence was provided to the required adults and the necessary collaterals were contacted. OCDSS referred the family to Early Intervention and a community agency for family therapy. OCDSS informed the mother if she did not address the sibling's behavioral and educational needs, OCDSS may need to file a petition in Family Court in the future.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/08/2019	Sibling, Female, 8 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 8 Years	Mother, Female, 34 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 8 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 6 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 6 Years	Mother, Female, 34 Years	Lack of Supervision	Unsubstantiated	

Sibling, Female, 6 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 4 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 4 Years	Mother, Female, 34 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 4 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 34 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Adult Sibling, Male, 16 Years	Mother, Female, 34 Years	Childs Drug / Alcohol Use	Unsubstantiated
Adult Sibling, Male, 16 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated
Adult Sibling, Male, 16 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 14 Years	Mother, Female, 34 Years	Childs Drug / Alcohol Use	Unsubstantiated
Sibling, Male, 14 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 14 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged the mother smoked marijuana with the then 16 and 14-year-old siblings on a daily basis. As a result, the siblings were getting high from the marijuana. The mother also left the then 7, 5, 4, and 2-year-old siblings home alone on a regular basis. The most recent incident occurred on 11/2/19, when the mother left the siblings unsupervised for several hours and she failed to make an adequate plan for their care.

Report Determination: Unfounded | **Date of Determination:** 11/27/2019

Basis for Determination:
There was a lack of credible evidence that the mother left the siblings unsupervised. She was observed to be supervising the siblings at all casework contacts. The mother admitted to occasional marijuana use when she was not caring for the siblings and she denied using marijuana with the siblings. The case planner denied any concerns for the mother's substance use or for supervision of the siblings. The mother was cooperative with services and the Preventive Services Case remained open.

OCFS Review Results:
OCDSS conducted home visits and assessed the home to be safe. They interviewed the mother, father and siblings and contacted relevant collaterals. Safety Assessments and the RAP were completed timely and accurately. Notice of Existence was provided to the required adults. Additional attempts to interview the fathers of the siblings were not documented.

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 siblings' fathers were added to the report as parents and notified about the investigation. Although it was identified that they visited the siblings, efforts to interview the fathers were not documented.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDSS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/10/2018	Sibling, Male, 13 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 13 Years	Mother, Female, 33 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Male, 13 Years	Mother, Female, 33 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
An SCR report alleged that on 10/6/18, the then 13-year-old sibling tripped over a cord and fractured his right femur. The mother was aware, but waited until 10/10/18 to seek medical treatment for the sibling. The explanation given was the sibling was roaming the street and the mother could not find him.

Report Determination: Unfounded | **Date of Determination:** 08/26/2019

Basis for Determination:
There was credible evidence gathered that the then 13-year-old sibling and adult sibling (then 16-years-old) were having behavioral issues and sneaking out of the home without the mother's permission. The then 13-year-old sibling was with a friend at an unknown location when he broke his leg. The mother said she was unable to locate the sibling until several days later, delaying her ability to obtain medical care. The mother said she had to care for the younger siblings and she could not go looking for the older siblings. The school filed a PINS petition on both siblings and the family was court ordered to work with Preventive Services.

OCFS Review Results:
Within the first seven days OCDSS conducted home visits and assessed the home to be safe. They interviewed the mother and siblings and contacted relevant collaterals. Safety Assessments were completed accurately and timely and Notice of Existence was provided to the required adults. Attempts to interview the father or the siblings' fathers were not documented. There was credible evidence to substantiate the allegation of Inadequate Guardianship against the mother as she had taken no steps to protect the oldest siblings or to correct their behavior. It was not documented why there was no case activity between October 2018 and May 2019 or why the investigation remained open for 10 months.

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 siblings' fathers were added to the report as parents and notified about the investigation. Although it was identified that they visited the siblings, efforts to interview the fathers were not documented.

Legal Reference:
18 NYCRR 432.1 (o)

Action:

OCDSS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Appropriateness of allegation determination
Summary:
There was credible evidence gathered to substantiate the allegation of Inadequate Guardianship against the mother.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
OCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Syracuse Regional Office if further guidance is needed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/06/2018	Adult Sibling, Male, 15 Years	Mother, Female, 33 Years	Educational Neglect	Substantiated	Yes
	Adult Sibling, Male, 15 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report alleged that the mother was aware the adult sibling (then 15-years-old) had 49 unexcused absences and he was in danger of failing the school year. The sibling was supposed to attend school from 3-5 PM; however, he had not attended school since 4/9/18. The mother did not attend four school meetings to discuss the sibling's educational progress and poor attendance.

Report Determination: Indicated | **Date of Determination:** 09/05/2018

Basis for Determination:
The sibling was struggling behaviorally in school and he was scheduled to have home tutoring. The mother did not follow thorough with tutoring and the sibling missed several months of school as a result. The sibling then was scheduled to begin an alternative education program from 3-5 PM and the mother did not communicate that she did not have transportation for the sibling to attend. The mother and sibling agreed that the sibling would attend school daily in the new school year. The mother declined preventive services and she agreed to pursue services from probation if the sibling's attendance issues resumed.

OCFS Review Results:
OCDSS conducted home visits and assessed the home to be safe. The mother, father and siblings were interviewed and Notice of Existence letters were provided to the required adults. Additional attempts to locate and interview the fathers of the siblings were not documented. Safety Assessments and the RAP were completed timely and accurately. Relevant collaterals were contacted and services were offered.

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 siblings' fathers were added to the report as parents and notified about the investigation. Although it was identified that they visited the siblings, efforts to interview the fathers were not documented.
Legal Reference:
18 NYCRR 432.1 (o)
Action:

OCDSS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

[redacted]

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

The mother had an extensive CPS history between 2003 and 2018 regarding the siblings. There were nine indicated CPS reports for allegations of Lack of Medical Care, Inadequate Guardianship, Parent's Drug/Alcohol Misuse, Educational Neglect and Inadequate Food/Clothing/Shelter due to the mother's marijuana use, the home was in deplorable condition, and the mother had a history of not meeting the siblings' medical, educational or supervision needs.

There were unfounded CPS reports in 2011 and 2013 for the allegations of Inadequate Guardianship, Parent's Drug/Alcohol Misuse and Lack of Supervision.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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: 01/07/2021

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 01/07/2021

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

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

Casework Contacts

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

Services Provided

	Yes	No	N/A	Unable to Determine
Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? 19 days late				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

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: Preventive Services were provided by OCDSS.				

Required Action(s)

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

Issue:	Timeliness of completion of FASP
Summary:	The initial FASP was due to be completed by 1/17/21 and it was completed and approved 26 days late on 2/12/21. The comprehensive FASP was due to be completed by 3/18/21 and it was completed and approved 19 days late on 4/6/21.

Legal Reference:	18 NYCRR428.3(f)
Action:	OCDSS will complete timely and accurate FASPs.

Preventive Services History

A Preventive Services Case was opened from 4/28/14-6/26/16 due to the adult sibling (then 11-years-old) being adjudicated a juvenile delinquent and the siblings having a history of poor attendance and behavioral issues. The home was deplorable, the mother used marijuana and she was leaving the siblings unsupervised. An Article 10 Neglect Petition was filed in July 2015 and the petition was adjourned in contemplation of dismissal. The mother complied with services and she engaged in substance abuse treatment and mental health services. The sibling's court orders expired, the siblings' attendance improved, and the mother maintained a clean and sanitary home and proper supervision.

A Preventive Services case opened on 5/23/19 following the school filing a PINS petition on the then 14 and 16-year-old siblings due to behavioral issues at school and in the community. The siblings' court orders expired and the case closed on 7/16/20, per the mother's request.

A Preventive Services Case opened on 1/7/21 due to the 16-year-old sibling's behavioral issues and truancy from school. The mother was overwhelmed caring for the siblings and the subject infant had a positive toxicology for marijuana. The mother did not cooperate with services and an Article 10 Neglect Petition was filed on 3/26/21. The siblings were placed with relatives following the infant's death.

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 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/26/2021	There was not a fact finding	There was not a disposition
Respondent:	058579 Mother Female 36 Year(s)	
Comments:	An Article 10 Neglect Petition was filed against the mother on 3/26/21 regarding the 16-year-old sibling. The petition was pending in Family Court at the time this report was written.	

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