Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-21-024

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

Issue Date: Nov 26, 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: 6 month(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 06/01/2021
Initial Date OCFS Notified: 06/01/2021

Presenting Information

An SCR report was received which stated that on 6/1/21, the mother left the subject child and two siblings in the care of her boyfriend while she ran errands. The mother's boyfriend fell asleep on the sofa with the subject child, and failed to ensure she was in a safe situation prior to falling asleep. As a result, a folding armrest fell on top of the subject child, restricting her breathing. When the boyfriend awoke, he found the subject child unresponsive. The boyfriend called 911 and notified the mother of the situation. Emergency responders performed cardiopulmonary resuscitation at the home and on the way to the hospital. Upon arrival to the emergency room, the hospital staff continued life saving measures, but were ultimately unsuccessful, and the subject child was pronounced deceased. There were additional concerns that the mother and her boyfriend failed to provide a hygienic living environment for the children, and there was drug use in the home.

Executive Summary

This fatality report concerns the death of a six-month-old female subject child that occurred on 6/1/21. On that same date, Onondaga County Department of Social Services (OCDSS) received the fatality report and investigated the child's death. An autopsy was completed, and the cause of death was noted as asphyxiation due to smothering. The manner of death was accidental.

At the time of the child's death, she resided with her mother, her mother's boyfriend (PS), and her two siblings, ages two and three years old. The child's father was unknown, and the biological father of the siblings was incarcerated. The investigation revealed that on 6/1/21, at approximately 1:00PM, the mother left all three children at home with her boyfriend while she went to the store. Prior to the mother leaving, the boyfriend used drugs and laid down in the living room to take a nap. The mother and her boyfriend had conflicting stories as to whether or not the boyfriend was aware he was left to care for the children, or if the mother left knowing the boyfriend was under the influence. When the mother returned home, she called her boyfriend to let her into the apartment as the door was locked. The boyfriend was awakened by his phone ringing, and when he got up, he noticed the subject child was on the couch and one of the couch cushions was covering her head and torso. The boyfriend denied placing the child on the couch at any time, and it was later revealed the mother had placed the child on her back on the couch prior to leaving for the store. The boyfriend removed the couch cushion and found the child face up and unresponsive. The boyfriend let the mother into the home and immediately contacted emergency services. An ambulance arrived and transported the child to a local hospital, where she was pronounced deceased at 6:12PM.

OCDSS spoke with family members and collateral sources, which included law enforcement, medical staff, daycare providers, and the medical examiner. Concerns arose surrounding the conditions of the home which was described as deplorable and uninhabitable. There were further concerns regarding drug use and that the mother left her children alone with an inappropriate caregiver. As a result, a neglect petition was filed in family court and the surviving siblings were placed in the care of their maternal great-grandmother. OCDSS found the mother and her boyfriend's actions and inaction caused harm to the subject child and therefore, indicated the report. Criminal charges were being considered by law enforcement and the district attorneys' office; however, there had been no arrests by the time the investigation was closed. A court ordered services case was opened in response to the fatality and remained ongoing at the time of this writing.

PIP Requirement

This review resulted in citations related to casework practice. In response, OCDSS will submit a PIP to their Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS will review the plan(s) and revise as needed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
OCDSS gathered information to determine the allegations and assess the safety of the surviving siblings.

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:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

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

Child Fatality Report

Date of Death: 06/01/2021 **Time of Death:** 06:12 PM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 02:44 PM
Did EMS 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
How long before incident was the child last seen by caretaker? 15 Minutes
At time of incident was supervisor impaired?

- ☒ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Impaired by illness
- ☐ Impaired by disability

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	Female	6 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)

LDSS Response

On 6/1/21, OCDSS received the subsequent SCR fatality report regarding the death of SC. OCDSS had been involved with the family since 4/12/21, after an initial CPS investigation was opened with concerns SM and MGM were using drugs while caring for their CHN and MGM had driven under the influence with the CHN in the car. From the time the initial report was received to the time of the fatality, OCDSS made one face-to-face contact with SM and her CHN, which occurred on 4/16/21. At that time, there were no concerns noted regarding the home environment or the CHN's safety. Upon receipt of the fatality report, OCDSS initiated their investigation within 24 hours and coordinated their efforts with

their MDT. The safety of the SSs was assessed.

On 6/1/21, OCDSS accompanied LE to the family's residence. OCDSS found the home in deplorable conditions, with garbage, mold, soiled diapers, and broken glass throughout. OCDSS noted there were no clear pathways, and a butcher knife was on the kitchen floor. Further, OCDSS observed marijuana and marijuana paraphernalia throughout the home in places accessible to the CHN.

On this same date, OCDSS met with SM and MGM. SM reported that 6/1/21 was a normal day. She explained she left all 3 CHN in PS's care while she went to the store around 1:00PM and he was aware she left. SM reported when she returned, she knocked on the door because it was locked, and PS let her in. She stated PS told her he had "dozed off" for 10 to 15 minutes and woke up to find a couch cushion over SC's face and SC not breathing. SM explained the cushion was in the middle of the couch and would flip down; the cushion fell easily. SM said she went inside and saw SC unresponsive, then called 911. The conditions of the home were discussed, and SM reported she knew the apartment was not safe for the CHN. SM stated PS used synthetic marijuana, but not around the CHN, nor did he usually leave the drugs accessible. SM denied drug or alcohol use.

A safety plan was implemented where the SSs would stay with MGGM, and SM was to be supervised around the SSs. OCDSS assessed the safety of MGGM's home and found no concerns, and the SSs were deemed safe in her care.

On 6/17/21, PS was interviewed. PS reported that on 6/1/21, he and SM were at home with the CHN. He explained he smoked "spike" prior to laying down for a nap. PS stated SM was aware he had smoked and knew he was sleeping when she left the home to go to the store. PS reported he was unaware of what time SM left and must have been asleep when she told him she was leaving. PS said he woke up to his phone ringing; it was SM, who was asking to be let inside. PS stated he had been sleeping on a mattress that was on the floor next to the couch, and when he got up, he saw SC on the couch, with the back cushion covering her head and torso. PS said SC was lying face up, and when he removed the cushion, he saw she was unresponsive. PS explained the SSs were not in the living room at that time and they were later found hiding in a bedroom. PS said he called 911 as he let SM into the apartment. PS reported they dropped the SSs off at MGM's house so they could go to the ER. PS stated he did not place SC on the couch, and assumed SM did before she left.

Throughout the investigation, OCDSS assessed the safety of the SSs and spoke with collateral sources. It was determined SM knowingly left her CHN in the care of PS shortly after he used drugs and was asleep. There were further concerns surrounding the hazardous home environment. OCDSS filed a neglect petition in family court, and on 6/30/21, SM consented to a removal and the SSs were placed in the care of MGGM. Further, the judge ordered supervised contact between SM and the SSs, and no contact with PS. At the time of this writing, there were no criminal charges brought against SM or PS regarding the fatality; however, LE was seeking such. The allegations in the report were substantiated, and a court ordered services case was opened.

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: This fatality investigation was conducted by the Onondaga County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was submitted for review by the Onondaga County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058802 - Deceased Child, Female, 6 Mons	058804 - Mother's Partner, Male, 26 Year(s)	DOA / Fatality	Substantiated
058802 - Deceased Child, Female, 6 Mons	058804 - Mother's Partner, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
058802 - Deceased Child, Female, 6 Mons	058804 - Mother's Partner, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
058802 - Deceased Child, Female, 6 Mons	058804 - Mother's Partner, Male, 26 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
058802 - Deceased Child, Female, 6 Mons	058803 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
058802 - Deceased Child, Female, 6 Mons	058803 - Mother, Female, 22 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
058805 - Sibling, Male, 3 Year(s)	058804 - Mother's Partner, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
058805 - Sibling, Male, 3 Year(s)	058804 - Mother's Partner, Male, 26 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
058805 - Sibling, Male, 3 Year(s)	058803 - Mother, Female, 22 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
058806 - Sibling, Female, 2 Year(s)	058804 - Mother's Partner, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
058806 - Sibling, Female, 2 Year(s)	058804 - Mother's Partner, Male, 26 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
058806 - Sibling, Female, 2 Year(s)	058803 - Mother, Female, 22 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

CPS Fatality Casework/Investigative Activities

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

Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
OCDSS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered within the required timeframes.

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: A court ordered services case was opened to address ongoing concerns following the fatality.				

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:
A neglect petition was filed after concerns arose regarding deplorable home conditions, drug use, and inappropriate supervision of the surviving siblings. The mother consented to removal and the siblings were placed in the care of their maternal great-grandmother.

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:**
06/29/2021	There was not a fact finding	Direct Custody to/or Continued with Relative (Article 10)
Respondent:	058803 Mother Female 22 Year(s)	
Comments:	A neglect petition was filed after concerns arose regarding deplorable home conditions, drug use, and inappropriate supervision of the surviving siblings. The mother consented to removal and the siblings were placed in the care of their maternal great-grandmother.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☒	☐	☐	☐	☐	☐	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐

Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☒	☐	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☒	☐	☐	☐	☐	☐	☐
Alcohol/Substance abuse	☒	☐	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☒	☐	☐	☐	☐	☐	☐
Other, specify: Court Ordered Services							
Additional information, if necessary: A court ordered services case was opened in response to concerns that arose during the fatality investigation. Additionally, the family was provided resources for grief counseling and funeral cost assistance.							

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:
OCDSS provided the family with grief services referrals for the siblings. Additionally, a court ordered services case was opened and the family was engaged in services at the time of this writing.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS provided the family with grief services referrals for the parents and other caregivers. Additionally, a court ordered services case was opened and the family was engaged in services at the time of this writing.

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? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections ☐ Had heavy alcohol use

☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ 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)
04/12/2021	Deceased Child, Female, 5 Months	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 5 Months	Mother, Female, 22 Years	Lack of Supervision	Substantiated	
	Deceased Child, Female, 5 Months	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 1 Years	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 1 Years	Mother, Female, 22 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 1 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 3 Years	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 3 Years	Mother, Female, 22 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 3 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 5 Months	Grandparent, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 5 Months	Grandparent, Female, 39 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 1 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Grandparent, Female, 39 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 3 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Grandparent, Female, 39 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 5 Months	Mother's Partner, Male, 26 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 5 Months	Mother's Partner, Male, 26 Years	Parents Drug / Alcohol Misuse	Substantiated	

Sibling, Female, 1 Years	Mother's Partner, Male, 26 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 1 Years	Mother's Partner, Male, 26 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Male, 3 Years	Mother's Partner, Male, 26 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 3 Years	Mother's Partner, Male, 26 Years	Parents Drug / Alcohol Misuse	Substantiated

Report Summary:
This SCR report was received with concerns MGM and SM were smoking marijuana and drinking alcohol to the point of impairment while caring for the SM's CHN. There were further concerns MGM drove under the influence with SM's CHN in the car, and although SM was aware, she did not intervene.

Report Determination: Indicated | **Date of Determination:** 07/08/2021

Basis for Determination:
OCDSS interviewed family and collaterals. SM and MGM denied the allegations. SM's residence was observed on 4/16/21 and noted to meet minimal standards and her CHN were deemed safe. OCDSS educated SM surrounding safe sleep practices. The 3yo SS would not engage in an interview at that time. The pediatrician was contacted, and no concerns were noted. OCDSS did not complete another home visit or make any additional face to face contact with the family until 6/1/21, after SC's death, and when the subsequent fatality report was received. OCDSS found evidence of drug use in SM's home; however, no evidence to support the allegations against MGM. The investigation was indicated and closed.

OCFS Review Results:
Concerns in the report were that MGM was driving under the influence; however, OCDSS did not contact LE as a collateral source until 6/2/21, after the subsequent fatality report was received. MGM resided with her two CHN, ages 11 and 14 years old. A home visit to MGM's residence was not completed, nor were her CHN interviewed or their safety assessed, until 7 weeks later when the fatality investigation began. The record did not reflect any additional attempts to interview the 3yo SS until after the fatality report was received.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The Seven Day Safety Assessment noted there were no safety concerns; however, MGM's children were not seen or assessed within that time period.

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

Action:
Within seven days of receiving a report, OCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/10/2020	Sibling, Male, 2 Years	Grandparent, Male, 46 Years	Lacerations / Bruises / Welts	Unsubstantiated	Yes
	Sibling, Male, 2 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Male, 2 Years	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 11 Months	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 11 Months	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - MGM's CH, Female, 13 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated
Other Child - MGM's CH, Female, 13 Years	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - MGM's CH, Female, 10 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated
Other Child - MGM's CH, Female, 10 Years	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 2 Years	Grandparent, Female, 38 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 2 Years	Grandparent, Female, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 11 Months	Grandparent, Female, 38 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 11 Months	Grandparent, Female, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - MGM's CH, Female, 13 Years	Grandparent, Female, 38 Years	Inadequate Guardianship	Unsubstantiated
Other Child - MGM's CH, Female, 13 Years	Grandparent, Female, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - MGM's CH, Female, 10 Years	Grandparent, Female, 38 Years	Inadequate Guardianship	Unsubstantiated
Other Child - MGM's CH, Female, 10 Years	Grandparent, Female, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 2 Years	Grandparent, Male, 46 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 11 Months	Grandparent, Male, 46 Years	Inadequate Guardianship	Unsubstantiated
Other Child - MGM's CH, Female, 13 Years	Grandparent, Male, 46 Years	Inadequate Guardianship	Unsubstantiated
Other Child - MGM's CH, Female, 10 Years	Grandparent, Male, 46 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
This SCR report was received with concerns SM and MGM were smoking marijuana in the presence of the CHN. There were further concerns MGM drank alcohol to impairment and a sober caretaker was not available to adequately care for the CHN. The report also alleged MGM drove impaired with her CHN in the car, and the last incident occurred on 4/10/20. Additionally, MGM and MGF physically fought one another in the presence of the CHN on more than one occasion, one of which resulted in the 3yo SS being cut by a knife.

Report Determination: Unfounded | **Date of Determination:** 06/16/2020

Basis for Determination:
OCDSS interviewed family members and collateral sources. MGM and SM denied the allegations. OCDSS obtained LE records and noted there were no reports of concern. Services were offered but declined. The CHN were assessed as safe. By the close of the investigation, SM and the SSs were residing with MGM due to SM needing to secure new housing. MGM's home was observed and assessed as safe. Safe sleep education was provided. MGM and SM appeared sober during all interactions. The investigation was unfounded and closed.

OCFS Review Results:
The record did not reflect MGM's CHN were fully interviewed regarding the allegations in the report. The record did not reflect if a Notice of Existence Letter was sent to the SS's BF, or any attempts to speak with him. There were no documented attempts to interview MGF, who was named as a subject on the report.

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 record did not reflect MGM's children were fully interviewed regarding the allegations in the report.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
Throughout the CPS investigation, OCDSS must facilitate information gathering, analyses of safety factors and the inter-relatedness of risk influences and individual risk elements affecting family functioning.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The report alleged concerns surrounding possible domestic violence; however, this was not explored further with the children, MGM, or MGF.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
Prior to making a determination, OCDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Issue:
Failure to provide notice of report
Summary:
The record did not reflect if a Notice of Existence letter was sent to the biological father of the siblings.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The record did not reflect any attempts to speak with the biological father of the siblings.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:

OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Failure to Offer Appropriate Services
Summary:
The record did not reflect if domestic violence services were offered to the family.
Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
OCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
There were no documented attempts to interview MGF, who was named as a subject on the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/01/2018	Other Child - MGM's CH, Female, 11 Years	Grandparent, Male, 44 Years	Inadequate Guardianship	Substantiated	Yes
	Other Child - MGM's CH, Female, 8 Years	Grandparent, Male, 44 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 11 Months	Grandparent, Male, 44 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 11 Months	Grandparent, Male, 44 Years	Lacerations / Bruises / Welts	Substantiated	

Report Summary:
This SCR report was received with concerns the now 3yo SS was in a vehicle with SM, MGM and her CHN, and MGM's boyfriend (BFD), when MGF attempted to stab the BFD through an open car window. MGF missed the BFD and instead accidentally stabbed SS in the face, resulting in a laceration. Police were called and MGF was arrested.

Report Determination: Indicated | **Date of Determination:** 09/28/2018

Basis for Determination:
OCDSS completed interviews with family members and collateral sources. MGM and MGF's CHN were interviewed on 9/20/18. The older CH recalled the incident; however, denied seeing a knife or how SS was injured. The younger CH denied any recollection of the incident. Both CHN reported no safety concerns in their home. MGF was interviewed and reported MGM's BFD is the one who had the knife and SS must have gotten cut while MGF was attempting to get the knife away from the BFD. MGM was not interviewed. SS was observed and assessed as safe. SM's home was also observed with no concerns noted, and safe sleep practices were discussed. The investigation was indicated and closed.

OCFS Review Results:
The record did not reflect SM was interviewed about the allegations. NOE letters were not mailed within the required

timeframe. There were no attempts to speak with MGM's BFD. LE nor the hospital where SS was treated were contacted. The safety of MGM's CHN was not assessed within 7 days, and the safety assessments were inaccurate. MGM's CHN resided with MGM, MGGM and MA; however, the record did not reflect any attempts to assess the home or speak with the family. Information was gathered that MGM's BFD had previously threatened the CHN, but this was not addressed further. Diligent efforts to interview MGM were not made.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
Information was gathered that MGM's BFD had previously threatened the CHN, but this was not addressed further. It remained unclear if MGM would continue to have contact with BFD, or what measures would be taken to ensure the CHN's safety should contact with BFD continue.

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

Action:
Prior to making a determination, OCDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Issue:
Pre-Determination/Home Visit

Summary:
The record did not reflect a home visit to MGM's residence was completed.

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

Action:
Prior to making a determination, OCDSS will conduct one home visit with one face-to-face contact with the subject(s) and other person(s) named in the report so as to evaluate the environment of the child named in the report as well as other children in the same home.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The record did not reflect any attempts to interview the biological father of the SSs, MGM's boyfriend, or the other family members who resided in MGM's home and had regular contact with her CHN. Further, there was no documented contact with LE or the hospital where SS was treated for his laceration.

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

Action:
OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
The record did not reflect diligent efforts were made to interview MGM, including asking other household members of her whereabouts or how they may be able to get in contact with her.

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

Action:

The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
The record did not reflect SM was interviewed regarding the allegations in the report.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
OCDSS will make efforts to interview all persons named in a report, who may have been present during what was alleged in the report, and/or may have information pertinent to the safety and well-being of children that reside in the home.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The Seven Day Safety Assessment was inaccurate. Safety factors existed and a safety plan to ensure the safety of the children was needed (i.e., no contact with MGM's boyfriend). The safety of MGM's children was not assessed within 7 days, so it was unclear how OCDSS concluded there were no safety factors present.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Within seven days of receiving a report, OCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Issue:
Failure to provide notice of report
Summary:
Notice of Existence letters were not mailed within the required seven day timeframe.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, 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)
07/26/2018	Other Child - Unrelated CH, Male, 2 Years	Mother, Female, 20 Years	Lack of Supervision	Far-Closed	No
	Other Child - Unrelated CH, Male, 5 Years	Mother, Female, 20 Years	Lack of Supervision	Far-Closed	
	Other Child - Unrelated CH, Male, 9 Years	Mother, Female, 20 Years	Lack of Supervision	Far-Closed	

Report Summary:
This SCR report was received and appropriately tracked as FAR. The report alleged SM was caring for 3 unrelated CHN (ages 9, 5, and 1) when she left them home alone and unsupervised for an unknown amount of time. As a result, the CHN left the home and were found outside wearing no shirts, and the door to the home was locked.

OCFS Review Results:
OCDSS interviewed all individuals named on the report and collaterals. SS and the CHN in the home were deemed safe. OCDSS determined SM was babysitting the CHN and knowingly left them unattended for approximately 15 minutes while she went to the store; SM brought SS with her. Neighbors found the CHN on the front lawn without shirts on. SM stated this was the only time she left the CHN unsupervised. The CHN's mother reported she would no longer allow SM to watch her CHN or stay at her home. Additional concerns regarding the unrelated family were addressed by OCDSS. Services were offered to the families and the FAR investigation was closed. This investigation met all statutory requirements.

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

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

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

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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