Child Fatality Report

Report Identification Number: AL-23-022

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

Issue Date: Apr 29, 2024

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

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

☒ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.

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

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

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

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

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

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

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

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

Abbreviations

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

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Schenectady
Gender: Male
Date of Death: 12/05/2023
Initial Date OCFS Notified: 12/06/2023

Presenting Information

On 12/5/23, the Schenectady County Department of Social Services (SCDSS) learned of the death of the 2-year-old male subject child that occurred on the same date. There was an open CPS investigation at the time of the death, which began on 11/2/23. SCDSS notified the Albany Regional Office of the death via the 7065 Agency Reporting Form.

Executive Summary

On 12/5/23, SCDSS received notification that the 2-year-old child died on the same date. SCDSS had an open CPS investigation which began on 11/2/23, regarding concerns about poor supervision and domestic violence in the home. At the time of the death, the child resided with the mother, 5-year-old sibling, and 8-month-old sibling. The father did not reside in the home, and there was an Order of Protection barring contact by the father with the mother and children due to domestic violence. SCDSS assessed the safety of the siblings and determined they were safe in the care of the mother.

SCDSS learned of the death during a phone call with the mother on 12/4/23. SCDSS immediately began gathering information from family and collateral sources. It was determined that the death was not the result of abuse or maltreatment and there was no SCR report regarding the fatality. On 12/4/23, the mother was at home with the child and siblings. The mother observed that the child was having abnormal breathing during the morning, but was otherwise acting normally. The mother called the pediatrician and disclosed her concerns for the child and requested a script for Albuterol and a steroid. The mother did not receive a call back from the pediatrician or pharmacy. The child's condition remained the same through the early evening. The mother called the pediatrician and spoke to their on-call staff. The mother was advised to take the child to the hospital. The mother used a transportation service and brought all three children to the hospital.

The mother and children arrived at the hospital at 9:28 PM. The child was treated with an epi-pen, a nebulizer, and a CPAP machine. The child presented with no trauma and was admitted for issues related to asthma. The child's condition began to decline and medical staff administered life-saving measures. The child was unable to be resuscitated and died on 12/5/23 at 1:07 AM. An autopsy was completed and the child's manner of death was natural and the cause of death was respiratory failure, pneumonitis, and bronchopulmonary dysplasia.

A voluntary Preventive Services Case was opened to provide services to the parents and surviving siblings. SCDSS made referrals for bereavement counseling and burial expenses. The mother was previously engaged with community service agencies and continued her involvement with them. The CPS investigation open at the time of the death was unfounded and closed.

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

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:
There was no SCR report regarding the fatality and the completion of safety assessment tools was not required.

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:
SCDSS gathered information regarding the fatality. A Preventive Services Case was opened for the family.

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: 12/05/2023 **Time of Death:** 01:07 AM

Time of fatal incident, if different than time of death: 09:00 PM

County where fatality incident occurred: Schenectady
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 and/or ingested alcohol or drugs? No
Child's activity at time of incident:

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

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	Male	2 Year(s)
Deceased Child's Household	Mother	No Role	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Month(s)

LDSS Response

On 12/5/23, SCDSS received a telephone call from the mother and was informed of the subject child's passing. SCDSS interviewed the parents, spoke to relatives, gathered information from medical collaterals, assessed the safety of the surviving siblings, and made referrals for services.

SCDSS interviewed the mother regarding the events leading up to the child's death. The mother reported that the child was not feeling well and was having trouble breathing during the morning hours of 12/4/23. The mother called the pediatrician and disclosed her concerns for the child. During the call to the pediatrician, the mother also asked if a script for Albuterol and a steroid could be sent to the pharmacy. The mother stated that the child was treated at an urgent care recently, and they prescribed Albuterol and a steroid which helped with the child's breathing issues. The mother stated that she never received a call back from the pediatrician or the pharmacy. The child's condition remained the same through the early evening and the mother called the pediatrician and spoke to the on-call staff. The mother placed the call on speaker so the doctor could hear the child's breathing. The mother was advised to bring the child to the hospital for treatment. The mother brought the child to the hospital where his condition declined. The mother reported the staff did not have the proper equipment for pediatric care. Life-saving measures were unsuccessful and the child was pronounced deceased. The mother reported the family had on-and-off cold symptoms since the 5-year-old sibling started school. The child required breathing treatments on 12/3/23 and 12/4/23, but the mother stated he was otherwise eating and playing normally.

SCDSS spoke to hospital staff, who reported the child was admitted on 12/4/23 due to issues related to his asthma. The child was oriented and alert with some breathing issues. The child had no signs of trauma, had good hygiene, and appeared well cared for. While waiting to be transferred to another hospital, the child's condition declined and he became unresponsive. SCDSS inquired about any health and safety concerns for the child and none were reported. Following the death, the 8-month-old sibling was displaying symptoms of illness including wheezing. The sibling was treated at the hospital and SCDSS assisted in getting the sibling appropriate follow-up care.

SCDSS interviewed the staff at the pediatrician's office regarding their interactions with the family. Staff stated that the mother called on 12/4/23 at 8:00 PM, and they did not think she called earlier in the day for help. Staff confirmed the mother expressed her concern for the child's breathing and that she asked for a prescription. The mother was advised to go to the emergency room. When speaking with the child's pediatrician, SCDSS learned that the child had premature asthma and was not prescribed any medication. The child's last physical was on 7/18/23 and he was also seen on 10/11/23. The pediatrician stated they did not have any concerns about the mother's care of the children. SCDSS inquired with the mother about her phone calls to the pediatrician, and the mother showed SCDSS her cell phone call log, which showed calls to the pediatrician throughout the day on 12/4/23.

SCDSS completed visits to the home, interviewed the mother, father, and 5-year-old sibling, saw the 8-month-old sibling, and made referrals for services. Safe sleep guidance was reviewed extensively regarding the sibling and the family had appropriate provisions during home visits. Information was gathered regarding the subject child's death and it was determined the child died due to a medical cause. Medical collaterals reported no concerns for the mother's care of the child. A Preventive Services Case was opened to provide the family with ongoing support.

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 referred to an OCFS approved Child Fatality Review Team? No
Comments: SCDSS indicated on the completed 7065 form that the death would not be referred to their OCFS approved Child Fatality Review Team.

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?	☒	☐	☐	☐

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?	☐	☐	☒	☐
Explain: As there was no SCR report surrounding the fatality, the completion of safety assessments was not required; however, SCDSS documented an assessment of the siblings' safety following the death.				

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	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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	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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? Yes

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)
11/02/2023	Deceased Child, Male, 2 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 5 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Months	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 27 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 27 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 8 Months	Mother, Female, 27 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
An SCR report alleged that on multiple occasions the father physically attacked the mother in the presence of the children. In addition, the mother left the children home alone for several hours at night on multiple occasions.

Report Determination: Unfounded | **Date of Determination:** 01/26/2024

Basis for Determination:
SCDSS determined that based on the information gathered, there was no credible evidence to support detriment to the children regarding the allegations. The father denied the allegations and reported he had not seen the children since the OP was implemented in August 2023. The father had no concerns for the mother's supervision of the children. The mother denied the allegations and stated her brother was a support for the family and assisted with supervision as needed. The 5yo sibling was interviewed and did not disclose any safety concerns. The sibling denied that he was seeing his father.

OCFS Review Results:
SCDSS made home visits, completed interviews, and contacted collaterals. SCDSS extensively discussed the concerns regarding domestic violence with the parents. The Order of Protection was modified to a Refrain From Order following the death of the child, as the mother wanted the father's support. Following the death, SCDSS gathered information regarding the fatality and offered fatality-related services. A Preventive Services Case was opened for the family. Though safety was assessed within 7 days of receipt of the SCR report, the 7-day Safety Assessment Tool was completed 5 days late in CONNECTIONS.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
Though safety was assessed within 7 days of receipt of the SCR report, the 7-day Safety Assessment Tool was completed 5 days late in CONNECTIONS.

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

Action:
SCDSS will document and approve all Safety Assessments within the required timeframes.

PIP Requirement:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. SCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/01/2023	Sibling, Male, 3 Months	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 3 Months	Mother, Female, 27 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Male, 2 Years	Father, Male, 26 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 5 Years	Father, Male, 26 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 3 Months	Father, Male, 26 Years	Inadequate Guardianship	Substantiated	

Report Summary:

An SCR report alleged that the 8-month-old sibling was born with undeveloped eyes and required medical follow-up treatment to prevent blindness. The mother was aware and failed to follow through or provide the sibling with any alternative treatment. As a result, the sibling missed an appointment on 6/14/23.

Report Determination: Indicated | **Date of Determination:** 10/24/2023

Basis for Determination:
SCDSS unsubstantiated the allegations against the mother. During the investigation, there was an incident between the mother and father, in which the father was making threats to the mother and children, resulting in the need for SCDSS to provide emergency housing to keep them safe. The mother worked with a DV advocate to get an OP against the father, which remained in place protecting the mother and children at case closure. Family court requested a Court Ordered Investigation. SCDSS provided the mother with transportation to bring the 3-month-old sibling to an appointment for his eye condition.

OCFS Review Results:
SCDSS completed visits and interviews with the family, reviewed safe sleep guidance, and spoke to service providers. The mother was connected to community services and they were assisting with arranging mental health services as requested by the mother. The 8-month-old sibling was evaluated by Early Intervention during the investigation. The RAP did not accurately reflect the mother's mental health. There was an attempted phone call to the initial source; however, no further efforts were documented. The CPS history check was not documented.

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

Issue:
Review of CPS History
Summary:
A CPS history check was not documented.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, SCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, SCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.
PIP Requirement:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. SCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The mother's mental health was not accurately documented within the RAP.
Legal Reference:
18 NYCRR 432.2(d)
Action:
SCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/28/2023	Deceased Child, Male, 2 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes

Sibling, Male, 4 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 2 Years	Father, Male, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 4 Years	Father, Male, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated

Report Summary:
An SCR report alleged the home was falling apart structurally and was bug-infested. On 3/27/23, the stove caught on fire, further details were unknown. The mother was nearly evicted due to nonpayment. The mother had no money to feed the children. The mother suffered from borderline personality disorder and was often aggravated, yelled, and slammed things.

Report Determination: Unfounded | **Date of Determination:** 06/27/2023

Basis for Determination:
SCDSS unfounded the SCR report following the completion of home visits, interviews with the family, and collateral contacts. The parents reported the stove needed repairs and they put in a request; however, it was not completed before catching on fire. The landlord had since changed the stove. There was ample food in the home and the family received food stamps. The mother reported she did get easily frustrated, but it did not impact her ability to parent the children, and there was no evidence of this otherwise.

OCFS Review Results:
SCDSS completed home visits, family interviews, and interviews with collaterals. The family had appropriate provisions for the children and SCDSS assisted with supplies as needed. The 8-month-old sibling was born prematurely during the investigation. Once discharged home, SCDSS reviewed safe sleep guidelines and noted the family had safe sleep provisions. The RAP did not reflect the mother's mental health and 7 of the progress notes were entered more than a month after their event dates. There was a DV incident by the father against the mother and a refrain from OP was in place at case closure. The incident was addressed and the mother was offered assistance but declined.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
SCDSS documented 7 out of 26 progress notes more than a month after their event dates.

Legal Reference:
18 NYCRR 428.5

Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

PIP Requirement:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. SCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/09/2021	Deceased Child, Male, 8 Months	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The mother had a history of being out of control while caring for the subject child. The last known occurrence was on 9/9/21, when the mother was verbally aggressive and lunged towards others while upset. No one sustained injuries during

the occurrence.

Report Determination: Unfounded	**Date of Determination:** 10/22/2021

Basis for Determination:
SCDSS unfounded the report, as they determined there was no credible evidence to support the allegation of Inadequate Guardianship. The mother admitted that she had a disagreement with medical staff regarding the treatment and quality of care of the child. The mother had PTSD due to the loss of another child at the hospital over a year prior and was easily upset when it came to her children. The mother did not assault anyone or put the child in immediate danger at the time of the incident. The mother was cooperative, sober, and coherent at all home visits.

OCFS Review Results:
SCDSS conducted numerous home visits and assessed the safety of the sibling and child throughout the investigation. SCDSS spoke to collateral contacts, who reported no concerns for the care of the children. Medical collaterals had no concerns for the family, other than the mother's behaviors during their interactions with her. The record did not reflect that safe sleep guidance was reviewed with the family.

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

Issue:
Failure to provide safe sleep education/information

Summary:
The record did not reflect that safe sleep guidance was reviewed with the parents regarding the then 8-month-old subject child.

Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:
SCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/08/2021	Sibling, Male, 2 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 1 Months	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged that the mother had bipolar disorder, personality disorder, and anxiety. The mother gave birth to the subject child at 27 weeks gestation. The mother's behaviors in the hospital were erratic and she had to adhere to a behavior plan if she wanted to see the child. The mother was swearing, breaking objects, spitting in people's faces, and pacing. The mother was the caretaker of the sibling as well. Over the weekend, the mother was so out of control she was unable to see the child. The mother was calling nonstop and screaming at whoever answered. The police were sent to check on her mental health status. The mother continued to be erratic and unable to care for the child.

Report Determination: Unfounded	**Date of Determination:** 04/15/2021

Basis for Determination:
SCDSS determined there were no apparent safety factors at the time of the investigation. The report was unfounded and closed due to a lack of credible evidence to support the allegations. The mother's mental health was being treated and was not impacting her ability to care for her children. The father had an active parenting role and there were no concerns for him.

OCFS Review Results:

SCDSS completed home visits, family interviews, and interviews with collaterals. The mother was successfully engaged in mental health counseling, and during casework contacts, the mother's mental health did not appear to impact her parenting. It was learned the subject child's meconium tested positive for marijuana. The mother admitted to using during the first trimester, but not since. A Plan of Safe Care was completed. The child had several medical issues due to his prematurity and remained hospitalized at case closure. A report would be made to the SCR in the event the child was ready for discharge and there was a concern for the parents' ability to provide his required level of care.

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

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

Between 2018 and 2019, the mother had three unfounded CPS investigations, which included allegations of Inadequate Guardianship, Lacerations/Bruises/Welts, and Lack of Supervision regarding the 5-year-old sibling.

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