Child Fatality Report

Report Identification Number: NY-23-126

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

Issue Date: May 06, 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		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 12/22/2023
Initial Date OCFS Notified: 12/22/2023

Presenting Information

An SCR report was received and alleged on 12/22/23, after 1:00AM, the mother fell asleep with the subject child in the twin sized bottom bunk bed. The bed had blankets, sheets and pillows which created an unsafe sleeping situation for the child. The mother felt the subject child turn over at 3:00AM indicating the child was still alive at that time. The mother then went back to sleep and awoke at an unknown time later that morning. When the mother awoke, the subject child was not breathing, and the mother called 911 at 8:00AM. When the first responders arrived, they began cardiopulmonary resuscitation. The subject child was taken to the hospital where she was declared deceased at 9:10AM.

Executive Summary

This report concerns the death of a 2-month-old female child that occurred on 12/22/23. The Administration of Children's Services (ACS) received an SCR report on that same date, regarding the fatality. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother of the subject child. At the time of her death, the subject child resided at a local shelter with her mother and siblings, ages 2 and 5-years-old. The father resided locally and was not involved with the incident. In addition, there were two surviving half-siblings, ages 12 and 14 years old, their whereabouts were unknown, and it was unclear if they had met the subject child or surviving siblings. ACS immediately initiated their investigation and assessed the surviving siblings to be safe in the care of their maternal aunt and the maternal grandmother. After the fatality, the mother was very distraught and was hospitalized for several days.

Through a joint investigation with law enforcement, it was learned on 12/21/23, the family was staying at a shelter and was told they had to relocate to a new shelter and arrived at the new shelter at around 10:30PM. Upon arrival at the shelter, the mother asked the staff for a crib several times and it was arranged that the Department of Homeless Services (DHS) would drop off a Pack 'N Play; however, it never arrived that evening. The mother co-slept with the subject child on a bunk bed and around 8:00AM on 12/22/23, the mother woke and found the child unresponsive. The mother immediately contacted 911 and attempted life-saving efforts. Emergency medical services arrived and took over life-saving efforts. The child was transported to the hospital and pronounced deceased at 9:10AM on 12/22/23.

ACS communicated with the law enforcement and learned there was no criminality regarding the fatality and the criminal investigation was closed on 1/17/24. ACS communicated with the medical examiner's office and learned the autopsy was completed on 12/24/23, the cause of death was unexplained sudden death (extrinsic and intrinsic factors identified), and the manner of death was undetermined. The subject child was observed and there were no signs of abuse, trauma, or foul play. The subject child was described as having normal development and was in good health.

ACS appropriately unsubstantiated the above referenced allegations against the mother. Although the mother co-slept with the subject child, it was not the intention of the mother to co-sleep. The mother asked the shelter for a crib so she could have a safe sleep environment for the child. The shelter failed to provide the mother a safe sleep environment until the morning after the fatal incident had already occurred.

ACS discussed bereavement services with the mother and father. The mother was working with counseling services at the time of case closure. Burial assistance was discussed with the maternal grandmother, but it is unclear if financial assistance was provided to the family. ACS referred the family to numerous services such as, early intervention, Office for People with Developmental Disabilities, preventive services, and assisted the mother with obtaining a daycare voucher for

the 2-year-old surviving sibling. The mother accepted preventive services and at the time this report was written, the family was actively engaged.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS 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?** 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:
ACS made an appropriate decision to unsubstantiate the allegations based on evidence obtained throughout their investigation.

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

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/22/2023 **Time of Death:** 09:10 AM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:00 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ 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	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Other Household 1	Father	No Role	Male	26 Year(s)

LDSS Response

On 12/22/23, ACS received an SCR report regarding the death of the SC. ACS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ACS contacted the source of the report, reviewed CPS history, and notified the district attorney and medical examiner. ACS immediately assessed the surviving siblings to be safe in the home and in the care of their maternal grandmother.

ACS completed a home assessment of the maternal grandmother's home where the surviving siblings were staying while the mother was hospitalized; there were no concerns noted. ACS attempted interviews with the 2 and 5-year-old surviving siblings but due to their ages and development, neither were able to complete an interview. The maternal grandmother reported no concerns for the mother's parenting abilities.

ACS interviewed the shelter staff on 12/22/23. During the interview, staff confirmed the mother arrived at the shelter around 10:30PM the night prior. In addition, they confirmed the room only had bunk beds and that they had attempted to

deliver a crib in the morning, but the child had already passed away.

ACS interviewed the mother on 12/28/23, regarding the fatality. During her interview, she explained the day prior to the fatality on 12/21/23, she was at DHS waiting to be placed in a new shelter. Around 10:30PM, the mother reported arriving at the new shelter with none of her belongings except the carrier for the subject child due to not being allowed to have anything at DHS. The mother reported upon arrival, she asked the shelter staff for a crib and was told she would receive one in the morning. The mother explained she and the subject child co-slept on the bottom bunk bed. The mother indicated she was on the outside of the bed and the child was closest to the wall. Between 2-3:00AM, the mother woke to feed the subject child and they both went back to sleep. Around 8:00AM, the mother woke again and was lying next to the child, she denied being on top of or on the child. The mother attempted to wake the child and was unable to; she felt the child's hand and one felt warm while the other felt cold. The mother immediately contacted 911 and while waiting for EMS, her doorbell rang, and it was the shelter staff delivering the crib. The mother asked the shelter staff for help and the staff found someone to assist. EMS arrived and attempted life-saving efforts; the subject child was transported to the hospital by ambulance. The mother and siblings were escorted to the hospital by law enforcement. Shortly after the subject child arrived at the hospital, she was pronounced deceased on 12/22/23 at 9:10AM.

ACS spoke with the father via phone as he would not disclose his location. During his interview, he explained he was not present during the incident that led to the fatality. He reported the mother was logged out of the shelter she was residing at and was told to go to DHS with the children. The father explained the mother was relocated to a new shelter and when she got there, they were unaware she had an infant, and they did not have a crib for the subject child. The father reported no concerns for the mother's parenting abilities.

ACS conducted an Initial Child Safety Conference (ICSC) on 12/27/23 with the mother. There was no request for court intervention and the mother was referred to preventive services, which she accepted.

ACS communicated with collaterals such as the surviving siblings' pediatricians, school, the mother's mental health provider, shelter staff, law enforcement, hospital staff, and family members. The investigation was closed on 2/20/24, and the Preventive Services Case remained open at the time this report was written.

Official Manner and Cause of Death

Official Manner: Undetermined
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 referred to an OCFS approved Child Fatality Review Team?No
Comments: The New York City Region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
067079 - Deceased Child, Female, 2 Month(s)	067081 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
067079 - Deceased Child, Female, 2	067081 - Mother, Female, 28	Inadequate	Unsubstantiated

Month(s)	Year(s)	Guardianship	

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:

ACS attempted to interview both children; however, were unable due to developmental disabilities and age. ACS made multiple attempts to speak with the father in person, but he would not make himself available.

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 family was offered preventive services which the family accepted. Burial assistance was offered to the maternal grandmother; however, it was unclear if the family accepted.				

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	☐	☐	☐	☐	☐	☒	☐

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 family was referred for bereavement counseling and offered burial assistance. The 2-year-old surviving sibling was referred for early intervention, and the mother was offered a daycare voucher. At the time of case closure, the family was engaged in preventive services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was referred for bereavement counseling and offered burial assistance. It was unclear if the mother accepted burial assistance. The 2-year-old surviving sibling was referred for early intervention, and the mother was offered a daycare voucher. In addition, housing assistance was discussed with the mother. At the time of case closure, the family was engaged in preventive services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs

☐ Used marijuana
☒ Was not noted in the case record to have any of the issues listed

Infant was born:
☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ With none of the issues listed noted in case record

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)
01/06/2023	Other Child - unrelated household members child, Male, 12 Years	Mother, Female, 27 Years	Educational Neglect	Unsubstantiated	Yes
	Other Child - unrelated household members child, Male, 12 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 4 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 27 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received and alleged the children ages 12, 10 and 5 years old were irresponsible, immature, got into trouble and required a close level of supervision. Every day, the SM left the children home alone and unattended. The children ages 12 and 10, missed excessive days of school and suffered academically in school.

Report Determination: Unfounded | **Date of Determination:** 02/21/2023

Basis for Determination:
ACS unsubstantiated the allegations of Inadequate Guardianship and Educational Neglect as they found that the children's basic needs were being met and the siblings were not school aged. The surviving siblings were 4 and 1 years old. The circumstances regarding the 12-year-old were not investigated.

OCFS Review Results:
ACS immediately initiated their investigation and spoke to the source of the report. A CPS history search was completed; however, was not documented correctly as the family had prior history. ACS explained the FAR process to the family which they accepted but the case was not tracked as FAR. An unknown child was listed on the report but there was no discussion with the parents regarding who that child was. The risk assessment was not completed correctly as it did not include the mother's history. The biological father was not added to the case and the unrelated household member was not interviewed.

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 12yo unrelated child listed on the investigation was not interviewed or seen. In addition, the unrelated household member was not engaged, and the BF of the SS's was never added to the case.

Legal Reference:
18 NYCRR 432.1 (o)

Action:

ACS will make casework contacts in accordance with 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:
Overall Completeness and Adequacy of Investigations
Summary:
Casework staff discussed the FAR process which the family was agreeable to and accepted. The case was not tracked as FAR and remained in the investigative track. In addition, the history search completed was not accurate as the mother had prior history.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
ACS will review and adhere to regulations regarding FAR practice and casework practice in general. Within five business days of report, ACS will review and document all CPS record(s) that apply to the prior reports where the current report involves a subject of the report, a child named in the report or a child's sibling named in the report.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP was completed incorrectly. The mother had previous history that was not identified during the initial search and was not documented in the RAP.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS 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)
03/29/2022	Sibling, Male, 4 Years	Mother, Female, 27 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 4 Years	Mother, Female, 27 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received and alleged the then 3yo SS had a developmental disability. In November 2021, it was recommended that the SM seek medical services for the then 3yo SS. The mother failed to follow through. The PGM had a medical diagnosis and was not physically able to care for the 3yo and 6-month-old SS's. The SM was aware but continued to leave the children in the PGM's care for extended periods of time. The SM failed to make an adequate plan of care for the children.

Report Determination: Indicated | **Date of Determination:** 06/21/2022

Basis for Determination:
Nassau County Department of Social Services (NCDSS) substantiated the allegation of IG against the SM regarding the then 3yo SS. The SM had been recommended to get the 3yo SS services for his developmental disability but did not have him engaged in services, despite being given referrals. The allegation of IG was unsubstantiated against the SM regarding the 6-month-old SS. The children were staying with PGM who was seen and was able to care for the children. There was no evidence to suggest that the plan the SM made for the children was not appropriate. The allegation of LMC was

unsubstantiated against the mother regarding the then 3yo SS.

OCFS Review Results:
NCDSS immediately initiated their investigation and spoke to the source of the report. A CPS history search was completed, and progress notes were entered timely. NCDSS worked in conjunction with ACS, interviews were completed with the parents and the children were observed numerous times. NCDSS spoke with several family collaterals and obtained information from the children's pediatrician, school, and law enforcement. Several services were discussed with the family. At the time of case closure, the family moved out of district and the children were residing with their MGM.

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

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

NCDSS substantiated allegations of Inadequate Guardianship and Lack of Supervision against the biological father regarding the surviving half-siblings. The investigation was received on 7/5/12 and was closed 9/20/12.

Oneida County Department of Social Services (OCDSS) substantiated allegations of Inadequate Guardianship and Parent's Drug Alcohol Misuse against the biological mother and biological father of the surviving half-siblings. The investigation was received on 6/10/14 and was closed on 8/13/14.

NCDSS substantiated allegations of Inadequate guardianship against the subject mother and biological father of the 5-year-old surviving sibling. There was an unrelated child who was confirmed maltreated by the subject mother and biological father. The investigation was received on 5/28/19 and was closed on 7/10/19.

NCDSS unsubstantiated allegations of Inadequate Guardianship, Inadequate Food Clothing Shelter and Parent's Drug Alcohol Misuse against the subject mother and biological father regarding the 5-year-old surviving sibling. The investigation was received on 5/29/19 and was closed on 7/16/19.

NCDSS unsubstantiated allegations of Inadequate Guardianship and Parents Drug Alcohol Misuse against the subject mother, maternal grandmother, and maternal aunt regarding the 5-year-old surviving sibling. The investigation was received on 10/29/20 and was closed on 12/2/20.

Known CPS History Outside of NYS

There was no know CPS History outside of NYS.

Preventive Services History

Oneida County Department of Social Services (OCDSS) opened a Preventive Services Case on 8/6/14. The service case was regarding the biological father and biological mother of the surviving half-siblings. OCDSS filed a neglect petition against the mother and father due to an incident on 6/10/14 that led to multiple arrests. There were concerns for illegal substances being accessible to the half-siblings. The case was closed on 5/29/15 as the mother moved out of state and the father was incarcerated.

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