Child Fatality Report

Report Identification Number: RO-23-017

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

Issue Date: Feb 22, 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 **Jurisdiction:** Wayne **Date of Death:** 08/29/2023
Age: 1 month(s) **Gender:** Male **Initial Date OCFS Notified:** 08/29/2023

Presenting Information

On 8/29/23, an SCR report alleged on the same day, at approximately 2:00AM, the mother fell asleep while feeding the 1-month-old subject child. At about 6:38AM, the mother woke up to find the child in her arms, not breathing, blue in color, and with blood coming from his nose. The mother called 911 but did not attempt cardiopulmonary resuscitation (CPR). The child was transported to the hospital by ambulance where he was pronounced deceased at 6:54AM. The roles of the father, the 13, 11, 1-years-old siblings and 9-month-old niece were unknown.

Executive Summary

This report concerns the death of the of the 1-month-old male subject child. On 8/28/23, Wayne County Department of Social Services (WCDSS) received an SCR report regarding the child's death. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother regarding the child. At the time of his death, he resided with his mother, father, his three siblings, ages 13, 11, and 1, as well as the maternal grandfather and 9-month-old niece. The grandfather was the guardian of the niece. The father had a 5-year-old child that resided with his mother and did not visit the father's home.

The night prior to the death the mother fed the child, changed his diaper, and laid him in the bassinet to sleep around 9:00pm, swaddled in a blanket. The mother woke up to the child crying between 1:00-1:30pm, and the mother brought the child to the parent's bed and fed him a bottle of formula. The mother was sitting in the bed propped against pillows and was cradling the child. The child's head was on her shoulder, and his mouth and face were facing out away from her body. The father was asleep in the bed, he was closest to the wall and his body was facing the wall. The mother fell asleep while feeding the child and woke up to her alarm at about 6:30am. The mother said the child was in the same position as he was when she fell asleep. The mother observed the child to be pale in color, he had blood by one nostril, and was unresponsive. The mother woke up the father and immediately called 911. The mother took the child outside and waited for first responders to arrive. EMS arrived and began resuscitative measures on the child and transported him to the hospital. Hospital staff took over life-saving measures; however, were unsuccessful and the child was declared deceased at 6:54am.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation was closed. The record reflected WCDSS spoke with the medical examiner and there were no signs of trauma or abuse to the child's body and toxicology reports were pending. Law enforcement investigated the child's death and at the close of the CPS investigation no arrests had been made. The criminal investigation remained open pending the final autopsy report.

WCDSS made home visits and interviewed the adults in the home and spoke with the verbal siblings. The 9-month-old niece and the 1-year-old sibling were observed and assessed to be safe in the home with the parents and grandfather. The father's 5-year-old child was seen and assessed safe with her mother in another county.

WCDSS offered the family bereavement services and the mother accepted. WCDSS completed a referral for trauma services. The father and grandfather declined bereavement services. The record did not reflect the parents were offered burial assistance. The 13-year-old sibling remained engaged with mental health counseling after the death. WCDSS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother. Although not intentional, the mother was aware of safe sleep guidelines, and the mother removed the child from the bassinet, fed the

child in the parent's bed, and fell asleep while feeding the child. The CPS investigation was unfounded and closed on 11/30/23.

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:
Casework activity was commensurate with case circumstances.

Was the decision to close the case appropriate? Yes
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 the case circumstance.

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: 08/29/2023 **Time of Death:** 06:54 AM

Time of fatal incident, if different than time of death: 06:40 AM

County where fatality incident occurred: Wayne
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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:

- [x] 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	Male	1 Month(s)
Deceased Child's Household	Father	No Role	Male	35 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	66 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Other Child - Niece	No Role	Female	9 Month(s)
Deceased Child's Household	Sibling	No Role	Male	13 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)

LDSS Response

On 8/29/23, WCDSS received an SCR report regarding the death of the SC. WCDSS initiated the investigation timely, coordinated their efforts with LE, and the ME’s office was notified. WCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. WCDSS conducted an initial home visit the same day the report was received and assessed the safety of the siblings.

SCDSS interviewed the parents and learned the SC woke up at about 1:30am to eat. The SC was asleep in the bassinet, and the SM brought the SC into the bed with her and fed him about 3 ounces of formula. The SM said she was sitting propped against pillows, cradling the SC, his head was on her shoulder, and his mouth and face were facing away from her body. The SM fell asleep and when she woke up the SC was still in the SM’s arms and was unresponsive. The father reported he awoke to the SM screaming and she handed him the SC, while she called 911. The father observed blood coming out of the SC’s nose. The father said he pushed on the SC’s chest to perform CPR and the SM came back into the bedroom and took the SC outside to wait for the ambulance. WCDSS completed a home visit and observed a bottle with about 1 ounce of formula left in it next to the bed and a bassinet in the parents’ bedroom that had one blanket in it, that was laid on the bottom.

The MGF reported the SM and SC went upstairs between 9:00-10:00pm the night before and the MGF went to bed around 1:00am. The MGF was asleep in his room and heard the SM yelling sometime before 7:00am. The MGF said the SC slept in the bassinet and he had no concerns for the SM's care of the children.

The 13 and 11yo SSs had no information regarding the events that led up to the death. The 1yo SS and the 9-month-old niece were assessed and were unable to be interviewed. The MGF was the legal custodian of the niece and WCDSS observed a portable crib in the MGF's room and reviewed safe sleep recommendations with the MGF. The father's 5yo OC was assessed safe with her mother in another county. The 5yo OC did not visit the father's home and visited with the father at the paternal grandfather's home.

WCDSS gathered information from collateral contacts including LE, EMS, hospital staff, the pediatrician, probation, substance abuse counselors, and relatives. The SM and father remained engaged in substance abuse counseling after the death. There were no concerns the SM was under the influence of any substances at the time of the SC's death. The child was in receipt of regular pediatric care and the pediatrician had no concerns for the siblings. A skeletal survey was completed on the SC after the death that revealed a "possible skull fracture"; however, the record reflected the ME did not feel the fracture contributed to the SC's death. It was determined the skull fracture was not a result of abuse or neglect, and it could have happened at birth. At the close of the CPS investigation the siblings and the 5yo OC were assessed safe. WCDSS unfounded and closed the case.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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: Wayne County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066068 - Deceased Child, Male, 1 Month(s)	066288 - Mother, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated
066068 - Deceased Child, Male, 1 Month(s)	066288 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Unsubstantiated

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:

WCDSS met with and interviewed all family members, conducted home visits, and spoke with numerous collateral contacts.

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	☒	☐	☐	☐

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?	☐	☒	☐	☐

Explain as necessary:
There was no removal regarding the surviving siblings.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Burial assistance was not offered to the parents. Bereavement services were offered to the mother; however, at the time the CPS investigation closed it was unknown if the mother engaged in the services. The 13yo SS remained engaged with counseling services after the death. WCDSS made an Early Intervention referral for the 1yo SS and the record did not reflect the outcome of that referral. The parents remained engaged with substance abuse services at the close of the CPS investigation.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
WCDSS offered the mother services for the SSs, and she declined. The 13yo SS remained engaged with mental health services after the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WCDSS offered the mother bereavement services, and she accepted. WCDSS made a referral for trauma services for the mother. At the close of the CPS investigation it was unknown if the mother engaged with the services. WCDSS offered the father and MGF bereavement services; however, they declined.

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
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ 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)
11/18/2022	Sibling, Male, 1 Years	Mother, Female, 34 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 1 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 10 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 10 Years	Father, Male, 36 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 12 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 12 Years	Father, Male, 36 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 10 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 10 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 12 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 12 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
WCDSS received a report from the SCR alleging the mother drank to the point of intoxication on 11/17/22. The siblings were present, and the mother engaged in a verbal altercation with her mother. During the altercation, the mother aggressively grabbed the then 1-year-old sibling. The mother had a history of alcohol misuse when the sole caretaker for the siblings and would become irate and agitated, slurred her speech, and was incoherent. A subsequent report was received on 11/23/22 alleging the father physically assaulted the mother in the presence of the then 12 and 10yo siblings and he physically assaulted the siblings in the past, leaving bruises on their backs and buttocks.

Report Determination: Indicated | **Date of Determination:** 01/04/2023

Basis for Determination:
WCDSS determined there was credible evidence to substantiate the allegations against the mother pertaining to the then-1-year-old sibling. The mother was intoxicated and became belligerent with the maternal grandmother when the maternal grandmother attempted to make a safety plan for the 1-year-old sibling. Law enforcement became involved and arrested the mother, confirming the mother was intoxicated and dropped the 1-year-old sibling during the altercation. The allegations against the father regarding the eldest siblings were unfounded, though the determination narrative does not speak to the circumstances surrounding the unfounding.

OCFS Review Results:
WCDSS provided safe sleep education to the mother and father. WCDSS assessed safety within the required timeframe and created a safety plan when it was determined the siblings were not safe in the care of the parents. WCDSS entered 10 of the 31 notes more than a month after their event dates. The investigation conclusion narrative did not consider, weigh, and evaluate all the information gathered and documented in the case record. Each allegation in the report was not individually addressed in the case record or in the investigation determination. The subsequent report allegations were

not addressed with the father nor were they included in the determination narrative.

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

Issue:
Appropriateness of allegation determination

Summary:
The investigation conclusion narrative did not consider, weigh, and evaluate all the information gathered and documented in the case record. Each allegation in the report was not individually addressed in the case record nor the investigation determination. A subsequent report contained new allegations against the father, which were not addressed.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
WCDSS will refer to the CPS Program Manual and/or consult with the Rochester Regional Office when determining the appropriateness of allegations and will take into consideration all information when applying the circumstances to the definition(s).

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
Although the Safety Assessments were completed timely, they were completed with regard to risk regarding the child, not the child's immediate or impending safety. As a result of the inaccurate Safety Assessments, the case was closed with a Safety Decision #3.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:
The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/28/2022	Sibling, Female, 17 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 17 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 10 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 10 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 12 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 12 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 6 Months	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Months	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

WCDSS received a report from the SCR alleging the mother was diagnosed with a mental health condition and was suffering from mental health issues. The mother was not receiving mental health treatment and was unstable in caring for the siblings who were 17, 12, 10, and 6 months old at the time. On the morning of 4/28/23, the mother was heavily intoxicated and was making threats of self-harm. The siblings were in the home at the time of the incident.

Report Determination: Unfounded | **Date of Determination:** 05/23/2022

Basis for Determination:
WCDSS determined there was no evidence to substantiate the allegations of IG and PDAM against the mother regarding the siblings. WCDSS found the mother had isolated herself from the siblings while she became intoxicated. The paternal grandfather and 17yo sibling were caring for the 6-month-old sibling. The 10 and 11-year-old siblings were with their father at the time.

OCFS Review Results:
WCDSS completed safety assessments and a review of CPS history within the required timeframes. WCDSS provided safe sleep education to the family. Medical concerns were revealed for the 6-month-old sibling, however, the investigation was closed prior to the concerns being followed up on. WCDSS attempted to call the mother's treatment provider two times in the week prior to closing the investigation but failed to make contact. WCDSS closed the investigation within 24 days of receipt without gathering information from the mother's treatment provider despite ongoing concerns for substance misuse and the mother's self-disclosure of suicidal ideations.

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

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

Summary:
Medical concerns were revealed for the 6-month-old sibling, however, the investigation was closed before the concerns were addressed. WCDSS attempted to call the mother's treatment provider twice in the week before closing the investigation but made no contact. WCDSS closed the investigation within 24 days of receipt without follow up from the mother's provider or sibling's pediatrician.

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

Action:
WCDSS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/08/2021	Sibling, Male, 9 Years	Mother, Female, 32 Years	Excessive Corporal Punishment	Unsubstantiated	No
	Sibling, Male, 9 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
Ontario County Department of Social Services (OCDSS) received a report from the SCR alleging the mother had a history of physically abusing the then 9-year-old sibling. On the morning of 3/8/21, the mother struck the sibling twice in the face. The mother allegedly struck the sibling in the face because he lied to her.

Report Determination: Unfounded | **Date of Determination:** 07/07/2021

Basis for Determination:
OCDSS determined there was no evidence to substantiate the allegations of IG and XCP against the mother regarding the sibling. The investigation revealed the siblings engaged in a physical altercation with each other and neither child was injured during the altercation.

OCFS Review Results:
OCDSS completed safety assessments accurately and within the required timeframes. OCDSS did not enter progress notes contemporaneous to their event dates, with 3 of the 16 notes entered three months after their event dates. OCDSS made an appropriate determination based on the information provided to them.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/02/2020	Sibling, Male, 10 Years	Mother, Female, 32 Years	Excessive Corporal Punishment	Unsubstantiated	Yes

Report Summary:
Ontario County Department of Social Services (OCDSS) received a report from the SCR alleging the mother punched the then 10-year-old sibling regularly and slaps him in the face as punishment for fighting with the then 8-year-old sibling. The mother physically hit the 10-year-old sibling on 12/1/20 and has left marks in the past.

Report Determination: Unfounded | **Date of Determination:** 12/20/2020

Basis for Determination:
OCDSS determined there was no evidence to substantiate the allegations of XCP against the mother regarding the 10-year-old sibling. Both the 10-year-old and 8-year-old denied that the mother punched either of them. They confirmed there was an altercation between the two, and the mother slapped the 10-year-old in the shoulder as a result. Neither sibling was observed with marks or bruises.

OCFS Review Results:
OCDSS completed the Risk Assessment Profile inaccurately causing a "very high" RAP rating score. OCDSS marked that a sibling was removed from the home before the current report due to abuse or neglect and remained with the substitute caregiver. This applies only to situations or circumstances that resulted in the removal of a child from the home, due to alleged or confirmed abuse. This involves removals by LE or another authorized person. The record did not reflect that a sibling was placed in foster care pursuant to an Article 10 Neglect or Abuse petition. It would have been appropriate for OCDSS to select "yes" for question 2, any child in the RAP family unit was in the care of custody of any substitute caregiver (informally or formally) at any time prior to the current report date, which would not have elevated the RAP rating to a "very high" score.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP was scored that a sibling was removed from the home prior to the current report due to abuse or neglect, causing a "very high" risk rating, however, the record did not reflect that a sibling was ever removed from the parents or that an Article 10 Neglect petition was filed on behalf of any of the siblings.

Legal Reference:
18 NYCRR 432.2(d)

Action:
OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

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

The family has an UNFOUNDED history dating back to 2005 with common allegations of Inadequate Guardianship,

Lacerations/Bruises/Welts, and Parent's Drug and Alcohol Misuse.
There was an INDICATED report from 2007 regarding the now-adult sibling. The mother and father of the siblings had a history of substance misuse and left the now-adult sibling with the maternal grandparents while they moved out of the state. The mother and father of the siblings failed to make a plan of care for the child and ultimately the maternal grandmother sought Article 6 custody through family court.

The 9-month-old niece had history unrelated to the fatality.

Legal History Within Three Years Prior to the Fatality

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

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