Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-22-049

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

Issue Date: Jun 08, 2023

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: 1 year(s)
Jurisdiction: Nassau
Gender: Female
Date of Death: 12/28/2022
Initial Date OCFS Notified: 12/22/2022

Presenting Information

On 12/16/2022, Nassau County Department of Social Services (NCDSS) received an SCR report alleging the mother found the 1-year-old subject child experiencing seizures and in medical distress; however, delayed contacting emergency medical services for over 2 hours. When EMS responded to the home, the mother was combative and impeded the provision of care for the subject child. The subject child was eventually transported to the hospital where she was sedated and intubated. A subsequent SCR report was received on 12/21/2022, alleging the subject child had suffered numerous traumatic injuries to her head and spine, for which the mother and father had no explanation. Brain death testing was conducted and the subject child was declared brain dead on 12/22/2022. A further SCR report was received alleging DOA / Fatality on 12/22/2022. The subject child was removed from life support systems on 12/27/2022, and declared deceased on 12/28/2022.

Executive Summary

This fatality report regards the death of the 1-year-old subject child which occurred on 12/28/2022. At the time of the incident leading to the child's death, the child resided with the mother, father, and the 13, 11, 5, and 3-year-old maternal half-siblings. The maternal half-siblings had infrequent contact with their respective biological fathers. There were 11, 8, and 2-year-old paternal half-siblings who resided with their mother and had sporadic contact with the father.

The mother woke sometime in the morning on 12/16/2022, and found the child had vomited, was crying, and tensing up. The mother rocked the child back to sleep; however, the child woke up again screaming and moaning. The mother forced the subject child's eyes open and saw the subject child was staring straight ahead and not reactive. The mother contacted 911. When first responders arrived at the home, the mother was combative and would not allow emergency medical providers access to the child. Eventually, first responders were able to begin life-saving measures and the child and mother were transported to the hospital. The child was then quickly moved to a second hospital.

While at the hospital, an emergency CT-Scan was performed on the child and showed brain hemorrhaging. Further medical assessment showed the child had suffered bilateral retinal hemorrhaging, subdural hematoma to her scalp, cervical cord and ligament edema, compression fractures to her C6, C7, T1, and T2 vertebrae, and had experienced prolonged seizure activity because of her physical injuries. Hospital staff including the attending physician, a neuro-radiologist, and an ophthalmologist stated the child's injuries were consistent with non-accidental trauma and there was a concern the child may have been shaken.

Brain death tests were conducted, and the child was declared brain dead at 4:34 PM on 12/22/2022. The parents were combative with hospital staff on multiple occasions and disagreed with the child's medical intake assessment and brain death diagnosis. The child was removed from life support systems on 12/27/2022 and pronounced deceased at 3:31 AM on 12/28/2022.

NCDSS spoke with the medical examiner who confirmed an autopsy was completed on 12/29/2022; however, the final autopsy report and death certificate remained pending at the time the CPS investigation was closed. The medical examiner did not provide preliminary details related to the autopsy or the suspected manner and cause of death. The law enforcement investigation remained ongoing at the time the CPS case was closed and was pending further interviews of the parents, the final autopsy report, and the death certificate.

The allegations regarding the child were substantiated against the mother and father. The investigation conclusion narrative noted there was a significant delay in contacting emergency medical services after the child was found vomiting and seizing, the mother interfered with medical providers at the home and at the hospital while they were attempting to provide lifesaving care to the child, and neither parent provided an explanation as to how the child sustained her injuries.

Allegations of Inadequate Guardianship were substantiated against the parents regarding the maternal half-siblings as the suspected injury and trauma which lead to the death of the subject child occurred while the maternal half-siblings were in the home and in the care of the mother and father. The maternal half-siblings were removed and placed in the care of the maternal grandmother.

Services were offered to the family related to the fatality. The mother and maternal grandmother accepted bereavement counseling on behalf of the maternal half-siblings. The CPS investigation was closed on 2/1/2023 and the family remained open with a court-ordered services case.

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

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:

NCDSS conducted an investigation that met all regulatory requirements and appropriately opened the family for court-ordered services.

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: 12/28/2022 **Time of Death:** 03:31 AM

Date of fatal incident, if different than date of death: 12/16/2022
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Nassau
Was 911 or local emergency number called? Yes
Time of Call: 05:29 AM
Did EMS respond to the scene? Yes
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

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	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Other Child - maternal half-sibling	Alleged Victim	Male	13 Year(s)
Deceased Child's Household	Other Child - maternal half-sibling	Alleged Victim	Male	11 Year(s)
Deceased Child's	Other Child - maternal half-sibling	Alleged Victim	Female	5 Year(s)

Household				
Deceased Child's Household	Other Child - maternal half-sibling	Alleged Victim	Female	3 Year(s)
Other Household 1	Other Adult - mother of the paternal half-siblings	No Role	Female	36 Year(s)
Other Household 1	Other Child - paternal half-sibling	No Role	Female	11 Year(s)
Other Household 1	Other Child - paternal half-sibling	No Role	Female	8 Year(s)
Other Household 1	Other Child - paternal half-sibling	No Role	Female	2 Year(s)
Other Household 2	Other Adult - father of the 5 and 3yo maternal half-siblings	No Role	Male	37 Year(s)
Other Household 3	Other Adult - father of the 13yo maternal half-sibling	No Role	Male	36 Year(s)
Other Household 4	Other Adult - father of the 11yo maternal half-sibling	No Role	Male	35 Year(s)

LDSS Response

NCDSS began their investigation immediately upon receipt of the 12/16/2022 SCR report. Interviews were conducted with the mother, the maternal half-siblings, the maternal grandmother, law enforcement, first responders, hospital staff, and the medical examiner. The district attorney's office was informed of the death.

The mother was interviewed at the hospital and later at the home. Both interviews were conducted with the father present. The mother was also interviewed by law enforcement separately. The mother provided conflicting details regarding the events of 12/15/2022 and 12/16/2022. The mother initially reported the subject child threw up once on the morning of 12/16/2022, and during a subsequent interview reported the subject child threw up multiple times overnight from 12/15/2022 to 12/16/2022. The mother reported to NCDSS that she woke to check on the child around 3:00 AM but reported to law enforcement that she woke around 2:00 AM. The mother stated she contacted 911 around 4:00 AM; however, NCDSS obtained a copy of the 911 call which occurred at 5:29 AM. The mother reported the subject child was doing well in the days leading up to 12/16/2022, and denied she or any person harmed the subject child.

NCDSS attempted to interview the father on multiple occasions. The father declined to answer most questions and repeatedly interfered with the interviews of the mother, telling her not to speak with NCDSS. The father denied he or any person harmed the subject child.

The maternal half-siblings were interviewed twice at the child advocacy center. The maternal half-siblings denied any physical abuse or violence towards themselves or the subject child and reported no immediate safety concerns for themselves regarding mother and father. The maternal half-siblings were removed and placed in the care of their maternal grandmother. Home visits were made and the maternal half-siblings were assessed to be safe in the home and care of the grandmother.

NCDSS contacted the mother of the paternal half-siblings who reported the father had infrequent contact with her children in the past 2 years. The mother of the paternal half-siblings denied any history of behaviors for the father that would lead her to suspect he would be violent toward the subject child. A home visit was made, and the paternal half-siblings were assessed to be safe in the home and care of their mother.

NCDSS made diligent efforts to contact the 3 biological fathers of the maternal half-siblings. Two of the biological fathers

engaged with NCDSS and reported they had infrequent contact with their children and had no specific concerns for them in the mother's household.

NCDSS interviewed the pediatrician for the subject child who reported having multiple concerns for the child in the past, related to the child's nutrition and diet as well as the mother and father's failure to follow through with medical recommendations. The pediatrician had no knowledge or concerns related to physical abuse of the subject child.

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? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063711 - Deceased Child, Female, 1 Yrs	063712 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
063711 - Deceased Child, Female, 1 Yrs	063713 - Father, Male, 40 Year(s)	Fractures	Substantiated
063711 - Deceased Child, Female, 1 Yrs	063713 - Father, Male, 40 Year(s)	DOA / Fatality	Substantiated
063711 - Deceased Child, Female, 1 Yrs	063712 - Mother, Female, 29 Year(s)	Lack of Medical Care	Substantiated
063711 - Deceased Child, Female, 1 Yrs	063712 - Mother, Female, 29 Year(s)	Internal Injuries	Substantiated
063711 - Deceased Child, Female, 1 Yrs	063712 - Mother, Female, 29 Year(s)	Fractures	Substantiated
063711 - Deceased Child, Female, 1 Yrs	063712 - Mother, Female, 29 Year(s)	DOA / Fatality	Substantiated
063711 - Deceased Child, Female, 1 Yrs	063713 - Father, Male, 40 Year(s)	Internal Injuries	Substantiated
063711 - Deceased Child, Female, 1 Yrs	063713 - Father, Male, 40 Year(s)	Lack of Medical Care	Substantiated
063711 - Deceased Child, Female, 1 Yrs	063713 - Father, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
063714 - Other Child - maternal half-sibling, Male, 13 Year(s)	063713 - Father, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
063714 - Other Child - maternal half-sibling, Male, 13 Year(s)	063712 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated

063715 - Other Child - maternal half-sibling, Male, 11 Year(s)	063712 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
063715 - Other Child - maternal half-sibling, Male, 11 Year(s)	063713 - Father, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
063716 - Other Child - maternal half-sibling, Female, 5 Year(s)	063712 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
063716 - Other Child - maternal half-sibling, Female, 5 Year(s)	063713 - Father, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
063717 - Other Child - maternal half-sibling, Female, 3 Year(s)	063713 - Father, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
063717 - Other Child - maternal half-sibling, Female, 3 Year(s)	063712 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:

NCDSS made and documented diligent efforts to contact all absent parents. One of the biological fathers of the maternal half-siblings did not respond to attempted contact and was not interviewed.

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 maternal half-siblings were removed and placed in the custody of their maternal grandmother on 12/23/2022. NCDSS filed petitions with family court on 12/28/2022. The court process remained ongoing at the time this report was written.

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

Explain as necessary:
The maternal half-siblings were placed in the care of their maternal grandmother due to concerns for the unexplained injuries to the subject child.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒ Family Court ☐ Criminal Court ☒ Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/28/2022	There was not a fact finding	There was not a disposition
Respondent:	063712 Mother Female 29 Year(s)	
Comments:	NCDSS filed petitions in family court against the mother and father regarding the surviving maternal half-siblings. The court proceedings remained ongoing at the time this report was written.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/28/2022	There was not a fact finding	There was not a disposition
Respondent:	063713 Father Male 40 Year(s)	
Comments:	NCDSS filed petitions in family court against the mother and father regarding the surviving maternal half-siblings. The court proceedings remained ongoing at the time this report was written.	

Have any Orders of Protection been issued? Yes	
From: 12/23/2022	**To:** Unknown
Explain: Orders of protection were put in place during an emergency family court proceeding. The father was ordered to have no contact with the surviving maternal half-siblings. The mother was ordered to have supervised contact only.	

Services Provided to the Family in Response to the Fatality

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

Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☒	☐	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☒	☐	☐	☐	☐	☐	☐
Other, specify: Court-Ordered preventive services							

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:
NCDSS offered grief counseling services which were accepted by the mother and maternal grandmother on behalf of the maternal half-siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
NCDSS offered fatality related services to the mother and father as well as the non-respondent parents. The mother accepted grief counseling.

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? No

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)
12/16/2022	Deceased Child, Female, 1 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	No
	Other Child - maternal half-sibling, Male, 13 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Other Child - maternal half-sibling, Male, 11 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	

Other Child - maternal half-sibling, Female, 5 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated
Other Child - maternal half-sibling, Female, 3 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 1 Years	Father, Male, 40 Years	Inadequate Guardianship	Substantiated
Other Child - maternal half-sibling, Male, 13 Years	Father, Male, 40 Years	Inadequate Guardianship	Substantiated
Other Child - maternal half-sibling, Male, 11 Years	Father, Male, 40 Years	Inadequate Guardianship	Substantiated
Other Child - maternal half-sibling, Female, 5 Years	Father, Male, 40 Years	Inadequate Guardianship	Substantiated
Other Child - maternal half-sibling, Female, 3 Years	Father, Male, 40 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 1 Years	Mother, Female, 29 Years	Fractures	Substantiated
Deceased Child, Female, 1 Years	Mother, Female, 29 Years	Internal Injuries	Substantiated
Deceased Child, Female, 1 Years	Mother, Female, 29 Years	Lack of Medical Care	Substantiated
Deceased Child, Female, 1 Years	Father, Male, 40 Years	Fractures	Substantiated
Deceased Child, Female, 1 Years	Father, Male, 40 Years	Internal Injuries	Substantiated
Deceased Child, Female, 1 Years	Father, Male, 40 Years	Lack of Medical Care	Substantiated

Report Summary:
The SCR report alleged the mother was aware the subject child was experiencing seizures and in medical distress but waited two hours before contacting emergency medical services. The mother then became combative with emergency medical providers. The subject child was transported to the hospital, sedated, and intubated, and was in critical condition.

Report Determination: Indicated | **Date of Determination:** 02/01/2023

Basis for Determination:
The allegations of IG, II, FX, and LMC were substantiated against the parents.

OCFS Review Results:
The 12/16/2022 initial investigation was conducted simultaneously with the fatality investigation. NCDSS conducted their investigation in accordance with all regulatory requirements and made an appropriate determination in congruence with the information received.

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)
08/04/2022	Deceased Child, Female, 8 Months	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 8 Months	Mother, Female, 28 Years	Lack of Medical Care	Unsubstantiated	

Deceased Child, Female, 8 Months	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 8 Months	Father, Male, 40 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
The SCR report alleged the mother and father were not providing adequate care to the then 8-month-old subject child. The parents were feeding the subject child hemp milk which caused her to be anemic with abnormal electrolytes. The parents were advised to switch the child to a different formula and refused to do so. The subject child was dehydrated and required an IV, which the parents also refused. A subsequent SCR report was received the same day and alleged the parents delayed seeking medical care for 2 days when the subject child had a fever of 103 degrees and had trouble breathing.

Report Determination: Unfounded | **Date of Determination:** 10/06/2022

Basis for Determination:
The investigation conclusion narrative noted the parents sought medical attention for the subject child when she had a seizure. There were concerns detailed by the first hospital treating the subject child; however, hospital staff at the second hospital reported no concerns for the parents' care of the subject child and discharged the child to the parents. The child's pediatrician reported no concerns for the subject child or siblings in the care of the parents. The allegations of Inadequate Guardianship and Lack of Medical Care were unsubstantiated against the parents.

OCFS Review Results:
There was a concern the parents did not follow through with medical recommendations and the record did not reflect follow-up regarding a scheduled hematology appointment. A review of the family's CPS history was not documented until 10/5/2022. The record did not reflect efforts to interview one of the absent fathers, nor did it reflect efforts to interview the other 2 absent fathers face-to-face. Documented interviews with the surviving siblings were lacking in detail and did not include key-safety related questions. The record noted the father had 3 children in another household; however, did not reflect efforts to ascertain if those children visited with the father or at the case address.

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

Issue:
Review of CPS History

Summary:
A CPS history check was completed untimely. The SCR report was received on 8/4/2022; however, the history check was completed on 10/5/2022.

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

Action:
Within 1 business day of a report, NCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, NCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

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

Summary:
Documentation of the interviews of the surviving siblings was lacking detail. The record did not reflect which children were asked which questions, nor did it reflect if the children were interviewed alone or as a group. There was also a lack of key safety-related questions.

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

Action:
NCDSS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and

every other child in the household should be interviewed prior to closing the investigation.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
The record did not reflect diligent efforts were made to interview the 3 absent fathers face-to-face.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
NCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
There was a reported concern that the parents were not following through with medical recommendations for the subject child. The subject child was referred by hospital staff to a post-discharge hematology specialist appointment; however, the record did not reflect NCDSS verified the subject child attended the appointment or gathered pertinent medical information related to such.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
NCDSS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.

[redacted]

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

An SCR report dated 7/29/2019 alleged IG against the biological father of the 3 and 5-year-old half-siblings regarding all 4 maternal half-siblings. The allegations regarded an incident when the biological father threw a telephone which struck the mother in the head. The mother and half-siblings denied the allegations and denied any violent behaviors in the household. The allegations were unsubstantiated.

An SCR report dated 12/5/2017 alleged EdN, IF/C/S, and IG which were substantiated against the mother regarding the 3 eldest maternal half-siblings. The family had been living in unsafe and unsanitary conditions while squatting in the basement of a home and the siblings missed a significant amount of school. Allegations of PD/AM were unsubstantiated against the mother.

An SCR report dated 4/3/2017 regarded allegations of LMC against the father and the mother of the paternal half-siblings regarding the then 2-year-old paternal half-sibling. The half-sibling was iron deficient and had been prescribed an iron supplement. Medical staff was concerned the parents were not providing the supplement or augmenting the half-sibling's vegan diet to provide proper nutrition. The pediatrician tested the half-sibling multiple times and on 5/22/2017 recommended she be hospitalized for further testing due to concerns for her iron level not improving. The investigation was unfounded and closed on 5/23/2017, and the record did not reflect further contact with any medical provider.

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