Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-016

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

Issue Date: Sep 26, 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: 3 month(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 04/06/2023
Initial Date OCFS Notified: 04/06/2023

Presenting Information

An SCR report alleged that on 4/6/23, the mother woke up at 5:00 AM to feed the subject child. The mother took the child from her crib to eat and after feeding her she placed the child into an infant swing and went back to bed. At 8:00 AM when the mother woke up, she found the child not breathing. The mother took the child out of the swing and placed her on the bed prior to law enforcement arriving. Law enforcement began cardiopulmonary resuscitation and emergency medical services arrived and transported the child to the hospital where she was pronounced deceased. A subsequent report received on the same date included allegations against the great-uncle pertaining to the subject child. The report alleged the great-uncle woke the mother up when the child was unresponsive and initiated cardiopulmonary resuscitation. The child was otherwise healthy and the mother had no explanation for her death.

Executive Summary

This fatality report is regarding the death of the 3-month-old female child that occurred on 4/6/23. Two SCR reports were made the same day and alleged DOA/Fatality and Inadequate Guardianship against the mother and the great-uncle regarding the subject child. At the time of her death, the child resided with her mother, great-grandmother, great-uncle, 15-year-old uncle, and two siblings, ages 1 and 5 years old. The siblings were assessed to be safe in the care of the mother.

The Orange County Department of Social Services (OCDSS) coordinated investigative efforts with law enforcement. It was learned on the morning of 4/6/23, the mother woke up around 5:00 AM and fed the subject child. The mother strapped the child into her car seat with a blanket situated underneath her and placed the car seat on the bed. The mother woke up around 8:00 AM and touched the child's foot, which was hanging out of the bottom of the child's footless sleep sack. The child's foot was cold to the touch. The mother picked the child up out of the car seat and tried to wake her up. The child was not breathing and the mother began to scream for help. The great-uncle heard the mother's screams and attempted to perform CPR on the child. The mother called 911 and first responders arrived and transported the mother and child to the hospital where she was pronounced deceased.

An autopsy was performed and the final results were not yet available at the time the CPS investigation was closed. OCDSS spoke with the medical examiner's office and attended a doll reenactment regarding the death. The medical examiner reported the cause and manner of death would be undetermined. Law enforcement investigated the death and there were no criminal charges at the time the CPS investigation was closed. The status of the law enforcement investigation at case closure was not documented.

The allegation of Inadequate Guardianship was incorrectly unsubstantiated against the mother regarding the subject child. The case record showed the mother was educated on safe sleep practices by OCDSS caseworkers and by hospital staff following the child's birth; however, the mother regularly placed the subject child in an unsafe sleep environment including in a car seat with a blanket inside, putting the child in imminent danger of harm. The allegation of DOA /Fatality was unsubstantiated against the mother. At the time the CPS investigation was closed, sufficient evidence was not gathered to corroborate that the mother was responsible for the death of the subject child. Allegations of Inadequate Guardianship and DOA/Fatality were unsubstantiated against the great-uncle, as OCDSS determined and wrote in their investigation conclusion narrative that there was insufficient evidence to substantiate the allegations.

Fatality-related services were provided to the mother, father, and surviving siblings. The mother enrolled herself and the 5-year-old sibling in mental health counseling. The CPS investigation was closed on 6/5/2023.

PIP Requirement
OCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS 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?** No

Explain:
Though sufficient information was gathered to determine all allegations, an incorrect determination was made in regard to Inadequate Guardianship.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
A preventive services case remained open to address concerns regarding the minor uncle. Although all other casework activity was commensurate with the case circumstances, the determination was not supported by the information gathered during the investigation.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Though the criteria regarding a fair preponderance of evidence was met with the information

	documented in the case record, OCDSS did not appropriately determine Inadequate Guardianship.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	OCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Westchester Regional Office if further guidance is needed

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/06/2023 **Time of Death:** 08:40 AM

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

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: 08:11 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	Aunt/Uncle	No Role	Male	15 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other Adult - Great-uncle	Alleged Perpetrator	Male	45 Year(s)
Deceased Child's Household	Other Adult - Great-grandmother	No Role	Female	70 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Other Household 1	Father	No Role	Male	25 Year(s)

LDSS Response

Upon receipt of the SCR report on 4/6/23, OCDSS coordinated efforts with law enforcement and the medical examiner, notified the district attorney and the Child Advocacy Center, completed interviews with the family, and assessed the safety of the siblings.

The mother was interviewed and reported that the morning of the death the mother woke up at 5:00 AM to feed the child. The mother placed the child back to sleep in her car seat with a blanket underneath her. The mother secured the child with the straps and put the car seat on top of the bed. The mother fell asleep next to the child on the bed and woke up at approximately 8:00 AM. The mother touched the child's foot, which was sticking out of the footless sleep sack she was in. The child's foot was cold so the mother picked the child up out of the seat and tried to wake her up. The child had one eye open and was not breathing. The mother screamed for help and the great-uncle attempted to do cardiopulmonary resuscitation on the child on top of the bed. The mother reported she observed what appeared to be milk on the side of the child's face. Emergency medical services responded and once the ambulance arrived the child was rushed to the hospital. The father did not reside in the home and was not present when the incident occurred. He reported no concerns for the care of the child. The mother stated it was her normal practice to place the child in the car seat to sleep because the child would cry when placed in her swing.

The other household members were interviewed. It was reported there was nothing out of the ordinary with the child the night prior to her death. The home members were alerted to the child being unresponsive when the mother began to scream. The great-uncle confirmed he performed CPR. The minor uncle and 5-year-old sibling were interviewed and reported no child welfare concerns. The 1-year-old sibling was not interviewed due to her age but was assessed to be safe.

OCDSS gathered records from the subject child's pediatrician which showed the child was seen at the practice on 2/22/23, 2/23/23, and 2/27/23 for concerns regarding a cough and mucus. The mother informed the pediatrician the symptoms had been ongoing since the child's birth. The child was diagnosed with a respiratory infection and the family was advised to return if it worsened or go to the hospital if emergent care was needed. The child was prescribed a 14-day medication. The records revealed that the child had slow weight gain, which was being monitored by the pediatrician through well-visits and weight checks. The siblings and minor uncle were in receipt of regular medical care and were up to date on their routine visits and immunizations. There were ongoing concerns for the minor uncle's truancy; however, OCDSS had preventive services in place to address the concerns at the closure of the CPS investigation.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064508 - Deceased Child, Female, 3 Mons	064513 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated

064508 - Deceased Child, Female, 3 Mons	064513 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
064508 - Deceased Child, Female, 3 Mons	064515 - Other Adult - Great-uncle , Male, 45 Year(s)	DOA / Fatality	Unsubstantiated
064508 - Deceased Child, Female, 3 Mons	064515 - Other Adult - Great-uncle , Male, 45 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:

The father of the 5-year-old sibling had been incarcerated since 2018. He was notified of the SCR report in writing.

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

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

Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? Yes

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)	Status/Outcome	Compliance Issue(s)
03/13/2023	Aunt/Uncle, Male, 15 Years	Other Adult - Great-grandmother , Female, 70 Years	Educational Neglect	Far-Closed	No

	Aunt/Uncle, Male, 15 Years	Other Adult - Great-grandmother , Female, 70 Years	Lack of Medical Care	Far-Closed
	Aunt/Uncle, Male, 15 Years	Grandparent, Female, 46 Years	Educational Neglect	Far-Closed
	Aunt/Uncle, Male, 15 Years	Grandparent, Female, 46 Years	Lack of Medical Care	Far-Closed

Report Summary:
An SCR report was received and alleged that the 15-year-old uncle was a special education student and he missed 50 days of school during the 2022-2023 school year. The uncle was failing his classes and not attending his counseling as a result of his absences. The grandmother and great-grandmother were aware and failed to address the concerns. The report was assigned to the Family Assessment Response (FAR) track.

OCFS Review Results:
OCDSS completed FAR tools, interviewed the MGM and great-grandmother (GGM), completed visits to the home, and conducted a CPS history check. OCDSS documented attempts to speak with the SM and assess the SC and SSs' safety; however, the SM refused contact with the FAR worker. OCDSS provided the GGM with literature on FAR, safe sleep, SIDS, and co-sleeping, which they requested be shared with the SM. A preventive services case was opened on 3/30/22, providing services to the MU regarding his truancy. The SC died during the open FAR case. A report was made regarding the death and OCDSS documented any other concerns would be addressed in that investigation.

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)
12/09/2022	Sibling, Female, 1 Years	Mother, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 1 Years	Mother, Female, 23 Years	Poisoning / Noxious Substances	Unsubstantiated	
	Sibling, Female, 1 Years	Other Adult - Great-grandmother , Female, 70 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Other Adult - Great-grandmother , Female, 70 Years	Poisoning / Noxious Substances	Unsubstantiated	

Report Summary:
On 12/9/22 and 12/10/22, SCR reports were received which alleged that on 12/9/22, the maternal great-grandmother left 15 of her pills in a cup accessible to the 1-year-old sibling. The sibling ingested the medications and became unresponsive while in the mother and great-grandmother's care. The sibling required medical treatment including Narcan.

Report Determination: Unfounded | **Date of Determination:** 02/15/2023

Basis for Determination:
OCDSS unsubstantiated the allegations. In the investigation conclusion narrative, OCDSS explained that when the SS exhibited symptoms of ingesting the great-grandmother's (GGM) medication, the SS was taken to the hospital. The SS was administered fluids and Narcan. The SS's drug screen returned negative for opiates. The parents reported the SS accessed the GGM's pills which were kept in an unsecured location. The GGM had been transported to the hospital earlier the same day for medical concerns. Following the incident, the parents put a gate across the GGM's room so the SSs could not access it. The GGM was elderly and medically fragile and did not always remember to secure her medicine.

OCFS Review Results:
OCDSS spoke to the sources of the reports, completed home visits, obtained school and medical records, and interviewed the parents, minor uncle, and now 5-year-old sibling. The 1-year-old sibling's safety was assessed. The record did not

reflect efforts to interview the adult uncle who resided in the home. The great-grandmother was not interviewed, though she was hospitalized during the investigation due to medical concerns. Preventive service providers did not have concerns for the family. The determination regarding the allegations was not supported by the information in the case record.

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

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

Summary:
It was documented that an adult uncle resided in the home; however, the record did not reflect he was added to the household composition, notified of the SCR report in writing and interviewed face-to-face.

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

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

Issue:
Appropriateness of allegation determination

Summary:
The record reflected that the 1-year-old sibling accessed the great-grandmother's bedroom. While in the bedroom, the sibling ingested pills that were sitting in a plastic cup on a television stand and overdosed on the medication. The sibling was home with the mother and unsupervised at the time of the incident. Despite this, the allegation of IG was unsubstantiated.

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

Action:
OCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Westchester Regional Office if further guidance is needed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/23/2022	Sibling, Female, 1 Years	Mother, Female, 23 Years	Lack of Supervision	Unsubstantiated	Yes

Report Summary:
An SCR report alleged that on 9/20/22, the mother left the 1-year-old sibling unsupervised in the home for approximately 5 minutes. Due to the sibling's age and maturity level, she required a higher level of supervision. The sibling was not harmed during the incident.

Report Determination: Unfounded **Date of Determination:** 11/15/2022

Basis for Determination:
The allegation of lack of supervision was unsubstantiated. The mother reported that she was getting the 5-year-old sibling from the bus stop and that the 1-year-old sibling was sleeping and alone for no more than 3 minutes. The mother reported she would not leave her children unsupervised again. There was no need for additional service interventions as all appropriate services and supports were already in place. No further CPS involvement was required at case closure.

OCFS Review Results:
Though not documented within the CPS investigation, the open FSS reflected an assessment of the children's safety within 24 hours of receipt of the SCR report. OCDSS spoke to the preventive caseworker, and service providers and retrieved pediatrician records. The mother was pregnant and OCDSS provided literature on the dangers of co-sleeping.

The mother and father were interviewed, the 1-year-old was assessed and attempts were made to interview the 5-year-old sibling. The record did not reflect that CPS history was reviewed. The record did not reflect efforts to notify or interview the 5-year-old sibling's father.

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

Issue:
Review of CPS History

Summary:
OCDSS did not document a check or review of the family's CPS history.

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

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
Though the father of the 5-year-old sibling was incarcerated, there were no efforts to otherwise notify him and facilitate a discussion regarding the SCR report.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDSS 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/24/2021	Sibling, Female, 2 Days	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 2 Days	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged that the mother gave birth to the now 1-year-old sibling, and the now 5-year-old sibling was still in foster care.

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

Basis for Determination:
The allegation of Inadequate Guardianship was unsubstantiated. While the 5-year-old sibling was in foster care at the time of the 1-year-old sibling's birth, the mother was engaged in services to address the concerns resulting in the 5-year-old sibling's placement. The mother was taking the 1-year-old sibling to her medical appointments and had not been exposed to any domestic violence.

OCFS Review Results:
Within 24 hours of receipt of the SCR report, OCDSS documented a CPS history check and a supervisory consultation. Though not documented within the CPS investigation, the open FSS reflected an assessment of the children's safety within 24 hours. OCDSS completed a home visit and clarified the household composition. OCDSS reviewed safe sleep guidance. Three home members, a child, and two adults, were not interviewed during the investigation. There was no casework activity documented between 8/30/21 and 10/18/21.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The case record reflected that there was no casework activity from 8/30/2021 to 10/18/21, during which the safety and risk for the family went unassessed.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
OCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the length of the investigation.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
It was documented that the great-grandmother, the adult uncle, and the minor uncle resided in the home; however, the record did not reflect they were interviewed.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

[redacted]

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

In 2019, the mother had two indicated SCR reports including the allegation of Inadequate Guardianship regarding the 5-year-old sibling. In addition, the minor uncle was listed on two SCR as a non-maltreated child. The allegations were Inadequate Guardianship, Parent's Drug/Alcohol Misuse, Excessive Corporal Punishment, and Lacerations/Bruises/Welts against the great-grandmother.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 03/30/2022

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐

Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☐	☒	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☐	☐	☒	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
A youth advocate program was providing services to the great-grandmother, grandmother and minor uncle.

Preventive Services History

Between August 2015 and October 2021, the minor uncle was listed as a services recipient due to concerns for his mother's mental health and alcohol abuse. In June 2015, the minor uncle was removed and placed in foster care with the great-grandmother. In January 2017, the great-grandmother was awarded Article 6 Guardianship of the minor uncle and his

services were ended.

In March 2022, OCDSS referred the great-grandmother, mother and minor uncle to a youth advocate program to address the concerns regarding the uncle's truancy and behaviors within the home and community. The uncle successfully participated in a variety of programs and activities. Though his attendance improved in the beginning of the 2022-2023 school year, it began to decline due to troubles with peers after January 2023. The advocate program was due to close in March 2023, after one year of provided services. Due to the ongoing concerns with the uncle's attendance, the family was referred to another program. The OCDSS services case in the grandmother's name was closed and a services case was opened for the great-grandmother and uncle, as the great-grandmother had custody of the uncle.

Foster Care Placement History

Between September 2019 and January 2023, the mother had a services case following the receipt of three SCR reports due to the mother stabbing someone in the presence of the 5-year-old sibling. A temporary plan was made for relatives to care for the sibling; however, the mother removed the sibling and in doing so violated the order of protection. A neglect petition was filed against the mother and she was asked to engage in mental health counseling and anger management. There were ongoing concerns for domestic violence perpetrated by the father, including strangulation and other physical violence. In February 2021, the mother consented to a finding of neglect and was court-ordered to have a psychiatric evaluation, complete anger management, enroll in recommended mental health counseling, and cooperate with service providers. The 1-year-old sibling was born on 8/22/21 and OCDSS filed a derivative neglect. The sibling remained in the mother's care with court-ordered supervision. The mother completed her recommended services and was enrolled in ongoing mental health counseling. The 5-year-old sibling was returned to the mother's care on 1/27/22 following a trial discharge. The mother gained part-time employment and was ensuring the siblings were in receipt of necessary medical care and educational services. OCDSS determined there were no further concerns and closed the case.

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