Child Fatality Report

Report Identification Number: SV-23-050

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

Issue Date: Dec 29, 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: 15 year(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 08/17/2023
Initial Date OCFS Notified: 08/18/2023

Presenting Information

An SCR report received on 8/18/23 alleged that on 8/17/23, the mother and subject child were engaged in a verbal dispute at approximately 10:20PM in their home. The mother left the room and heard a noise very soon after exiting the room. The mother returned and looked out of the window, which was on the second story of the building, and saw the child on the pavement below. The child sustained significant head trauma. Emergency services arrived and performed CPR. The child was pronounced deceased at 11:43PM on 8/17/23. It was unclear how the child exited the window. Two additional calls were made to the SCR on 8/18/23 which did not include allegations but included additional information related to the initial report. A fourth call to the SCR was made and a duplicate report was registered on 8/19/23 which contained substantively similar allegations to the initial fatality report.

Executive Summary

This report concerns the death of the 15-year-old subject child. Orange County Department of Social Services (OCDSS) received multiple SCR reports regarding the child's death, which occurred on the evening of 8/17/23. At the time of the child's death, she resided with her mother and 3-year-old sibling. The child's father had recently passed away in April 2023.

On 8/17/23, around 9:40PM, the subject child and mother were engaged in a verbal argument in the living room. Following the argument, the mother left the room with the 3-year-old sibling to put her to bed. Video footage taken from inside the home captured the scene. After the mother left the room with the sibling, the subject child went toward the window, opened it, hesitated a moment, and was seen leaving the camera's view, headfirst out of the window. After hearing a noise, the mother returned to the living room, saw the window open and the child on the ground below. The window was on the second floor. The mother called 911. Law enforcement officers arrived first and found the child lying face-down in a pool of blood. Upon feeling no pulse, they rolled the child over and initiated CPR. Emergency medical services arrived and took over life-saving measures. The child was in cardiac arrest and remained pulseless. The child was transported to the hospital via ambulance, where she was pronounced deceased at 11:43PM.

The medical examiner was notified and performed an autopsy of the child. The cause of death was "blunt impact injuries of head," and the manner of death was "suicide (descended from height of second-floor window)." Law enforcement investigated. Although no charges were anticipated in response to the fatality, the investigation remained ongoing at the time the CPS investigation was closed.

OCDSS made several home visits and interviewed the mother and relevant collaterals. The surviving sibling was assessed to be safe with the mother and remained in her care.

OCDSS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother regarding the subject child. The Investigation Conclusion Narrative noted there were no ongoing safety concerns for the sibling and there was not a fair preponderance of evidence to suggest the mother was responsible for the child's death. Services specific to the fatality were offered. The mother was repeatedly encouraged to engage in grief counseling services; however, had not done so at the time the investigation closed. Preventive services were offered and declined. OCDSS ensured the providers already working with the mother prior to the report were aware of the fatality.

PIP Requirement

For citations identified during this review, OCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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?** Yes

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:
Although all required casework and collateral contacts were made, progress notes were not entered contemporaneously with the occurrence of the event, or the receipt of the information.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	More than half of the progress notes, including notes that contained pertinent casework and collateral contacts, were entered 30 days or more beyond the event date.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/17/2023 **Time of Death:** 11:43 PM

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: 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:

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

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	15 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)

LDSS Response

On 8/18/23, OCDSS received multiple reports regarding the death of the subject child, which occurred on 8/17/23. OCDSS initiated their investigation within 24 hours, contacted the sources of the reports, completed a CPS history check, and informed the DA of the fatality. The safety of the surviving sibling was assessed, and a home visit was completed the same date the report was received.

The mother was interviewed regarding the events leading up to the child's death; however, often became overwhelmed with emotion and had difficulty describing the event. Neither the mother nor sibling were in the room when the child went out the window. The mother described she had left the room for a minute. She heard a noise, and when she came back into the room, the window was open. The mother expressed guilt at having yelled at the child. The mother denied any active mental health crises with the child, although the child had been seen in the emergency room in June 2023 after the mother brought her in for suicidal ideation. The mother stated she had tried to get the child to engage in counseling, but she refused.

OCDSS was able to obtain a timeline of events from collateral contacts. LE was the first to respond to the 911 call and were directed to the child's body by bystanders. Upon arrival, the child was face-down, with a pool of blood around her head. The child had landed between two air conditioning units, onto landscaping rocks. LE moved her away from the building and turned her over to initiate CPR. LE observed severe disfigurement to the child's face, including swelling, broken bones, and blood coming from the mouth, nose, and head. LE continued CPR until EMS arrived. LE interviewed a neighbor, who confirmed hearing arguing. Other bystanders only came outside after the incident had already occurred.

EMS reported upon arrival, the child had agonal breathing. An AED monitor showed no active heartbeat. Based on observed injuries, EMS posited the child landed face first. EMS placed the child into an ambulance and continued life-saving measures; however, the child remained in cardiac arrest and pulseless with ineffective electrical rhythm throughout transport. On arrival at the hospital, the child was turned over to the trauma team. Hospital records obtained showed advanced life-support was provided, with multiple attempts at cardiac resuscitation. The child suffered significant head and facial trauma that ultimately led to her death.

OCDSS reviewed records from the child's June 2023 emergency department visit which confirmed the mother brought the child to the hospital after she expressed suicidal ideation. Following an argument, the child picked up a knife and stated she did not want to live anymore. The record reflected the child adamantly denied intent to kill herself. The child had chronic self-injurious behaviors but denied depression, mania, or psychotic symptoms. At that time, the child did not require inpatient psychiatric admission. There were no further recommendations noted in the record.

School staff shared the child struggled academically and had some minor peer issues. The child had a 504 plan to address mental health needs, which were not further specified. The school had no safety concerns for the child and were surprised by the death. Pediatric records obtained also reflected no concerns.

The mother relocated during the investigation as she no longer wished to reside in the same apartment where the death occurred. The new apartment was assessed, and the mother was encouraged to follow up with counseling services that had been reaching out. The mother declined needing anything additional from CPS at that time and the case was closed.

Official Manner and Cause of Death

Official Manner: Suicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065208 - Deceased Child, Female, 15 Year(s)	065210 - Mother, Female, 43 Year(s)	DOA / Fatality	Unsubstantiated
065208 - Deceased Child, Female, 15 Year(s)	065210 - Mother, Female, 43 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?	☐	☒	☐	☐

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	☐	☒	☐	☐	☐	☐	☐
Other, specify: 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? No
Explain:
The mother requested grief counseling for the sibling; however, had not yet followed through on the referral provided at the time the CPS investigation closed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother requested grief counseling for herself and the sibling. The mother was referred to bereavement services immediately; however, was slow to engage. Despite continuing to express wanting grief counseling, and being encouraged multiple times to follow-up with providers who were reaching out to her, the mother had not yet engaged in counseling services for herself or the sibling. Other providers involved with the mother were aware of the fatality and remained involved.

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)
05/16/2022	Sibling, Female, 2 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 2 Years	Mother, Female, 42 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Female, 14 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report received on 5/16/22 alleged that the mother allowed a registered sex offender to be in the home and

around the children. It was unknown if the children had been touched inappropriately. On more than one occasion, the mother left the home after the subject child fell asleep, leaving the children unsupervised to go do laundry for an undetermined amount of time. Sometime prior to March 2022, the mother failed to provide adequate supervision of the sibling in that the mother left prescription medication accessible. As a result, the child ingested an unknown amount, and it was unknown if the child was seen medically.

Report Determination: Unfounded | **Date of Determination:** 06/14/2022

Basis for Determination:
OCDSS did not find a fair preponderance of evidence to support the allegations contained in the report. An interview with the mother revealed she obtained an Order of Protection against the sex offender. The mother denied ever leaving the children alone with the sex offender, and this was confirmed by the subject child as well. The subject child was interviewed and denied feeling unsafe or uncomfortable, and any inappropriate touching. The child denied being unsupervised for more than very short periods of time.

OCFS Review Results:
The investigation was initiated timely, and interviews were held with the mother and subject child immediately. OCDSS confirmed the mother's compliance with drug court and requested relevant records. OCDSS offered a referral for additional services, which the mother declined, stating she and the subject child had mental health providers. Not all allegations were addressed prior to determining and closing the investigation.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
The allegation regarding the mother leaving her prescription medication accessible and the sibling ingesting it was not explored.

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

Action:
OCDSS 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)
08/04/2021	Deceased Child, Female, 13 Years	Mother, Female, 41 Years	Other	Unsubstantiated	No
	Deceased Child, Female, 13 Years	Aunt/Uncle, Male, 32 Years	Other	Unsubstantiated	
	Deceased Child, Female, 13 Years	Father, Male, 48 Years	Other	Unsubstantiated	

Report Summary:
On 8/4/21, OCDSS received a Court Ordered Investigation from Orange County Family Court.

Report Determination: Unfounded | **Date of Determination:** 10/07/2021

Basis for Determination:
The subject child had been in the care of relatives for 2 years. Until recently, the mother had not been consistently involved in the child's life. The mother petitioned for custody of the child and a court-ordered investigation followed. The Investigation Conclusion Narrative noted the mother had prior substance misuse and was receiving services through drug court. The mother was compliant with services. The mother's residence with the sibling was assessed and no safety issues were noted. Neither were safety concerns noted in the subject child's residence with her relatives. At the time the case was closed, the custody matter had not yet been resolved in family court.

OCFS Review Results:

The COI was initiated and submitted timely. All children and adults, except for the subject child's father, were interviewed. The father was unable to be located despite efforts. The subject child expressed her desire to reside with her mother and be a part of the sibling's life. Records were noted to have been received from drug court, which outlined compliance and progress, as well as mental health services.

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)
12/18/2020	Sibling, Female, 10 Months	Mother, Female, 40 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 10 Months	Mother, Female, 40 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report received on 12/18/20 alleged that on an ongoing basis, the mother used heroin to the point of impairment while being the sole caretaker to the then 10-month-old sibling. While impaired, the mother would become unconscious and pass out. The mother's impairment made her an inadequate caretaker to the sibling.

Report Determination: Unfounded | **Date of Determination:** 02/02/2021

Basis for Determination:
The allegations of Parent Drug and Alcohol Misuse and Inadequate Guardianship were unsubstantiated against the mother regarding the sibling. The Investigation Conclusion Narrative stated the mother was involved with drug court, mental health, and various other service providers, who were spoken to and all stated that the mother had been sober and was following recommendations for her recovery. The sibling was thriving and there were no concerns for the sibling's care.

OCFS Review Results:
The investigation was initiated virtually, though a reason for the virtual contact was not documented. A follow up home visit was completed. The family was residing in a shelter and secured housing during the investigation although there was no documented home visit at the new residence prior to closing. Pertinent collaterals were not contacted timely and there were missed opportunities to gather additional information from collaterals. The subject child was residing with an uncle at the time and the uncle was not contacted, the subject child was not seen, and the frequency and quality of contact between the mother and subject child was not explored.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP was not scored to reflect the subject child as part of the family unit, despite the record reflecting her return home to the mother was an expected outcome. As a result, the subject child's alternative placement was not captured.

Legal Reference:
18 NYCRR 432.2(d)

Action:
This risk element would apply to situations where the parent was not able to provide parenting responsibility. The record reflected the subject child was with an uncle due to the mother's drug use. OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:

There were missed opportunities to gather collateral information from the subject child's caretaker, law enforcement regarding the alleged DV, and the mother's substance use provider.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

OCDSS will make diligent efforts to contact collaterals to potentially gather outside information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

[redacted]

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

The family's history with child welfare dates to 2008, when the SC was 5 months old. OCDSS opened an FSI in 2/2008, initiated by concerns of the mother's inpatient status due to drug abuse and the need to plan for the care of the SC. The mother was accepted into a long-term drug treatment program and the SC was able to reside with her mother in the treatment facility. In 2011-12, Sullivan County substantiated allegations of IG and PD/AM against the mother, as she had shoplifted and purchased drugs with the toddler SC present. The MGM obtained custody of the then 4yo SC. In 3/2014, a FAR case was initiated from concerns the MGM was aware her son, MU1, was using drugs in the home while caring for the SC. A May 2018 investigation by OCDSS was unsubstantiated for allegations of IG, PD/AM, and IF/C/S; however, in subsequent August and October 2018 investigations, the allegations of IG and PD/AM were substantiated against MU1 regarding the SC. The MGM had become ill, and the SC had been residing with the MU1. Due to DV and drug concerns, the SC went to reside with another uncle (MU2) who filed for custody of the SC. In 9/2019, OCDSS unsubstantiated allegations of IG and SA against MU1 regarding the SC. The SC denied the abuse by MU1 and stated it was her father when she was younger, which the mother confirmed. The record reflected the allegation had been previously investigated. The MU2 sought custody of the SC at the time the 2019 investigation closed.

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