Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-20-060

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

Issue Date: Jun 29, 2021

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 has an open 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		
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	
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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 10 year(s)
Jurisdiction: St. Lawrence
Gender: Female
Date of Death: 12/26/2020
Initial Date OCFS Notified: 12/28/2020

Presenting Information

St. Lawrence County Department of Social Services (SCDSS) received the SCR report on 12/29/20 which alleged that on 12/26/20 around 12:45 PM, the mother (SM) found the 10-year-old subject child (SC) unresponsive on the couch. The child was diagnosed with cerebral palsy, required feedings through a g-tube, was non-verbal, and wore a diaper. The report alleged that the child was extremely dehydrated at the time of her death and had been left in dirty diapers for extended periods of time resulting in ulcers on her buttocks and severe damage to her anal membrane. Upon finding the child unresponsive, the mother called 911. EMS responded to the home and transported the child to the hospital where she was pronounced dead. The roles of the 15-year old, 13-year-old, 12-year-old, 10-year-old, 6-year-old, and 4-year old surviving siblings were unknown.

Executive Summary

This report concerns the death of the 10-year-old subject child which occurred while in the care of her mother. The death of the child was reported to SCDSS through an SCR report on 12/26/2020 which identified concerns for the condition of the home. The report was made subsequent to an open investigation from 12/1/2020 that identified concerns for educational neglect of the children in the home. Initially, there were no concerns of abuse or maltreatment as the cause of death of the child and it was believed her multiple disabilities, including cerebral palsy with limited mobility, might have contributed to her death. The child was also non-verbal and required feedings through a G-tube throughout the day and overnight.

Initial familial interviews were conducted prior to receiving the fatality report. Through the familial and collateral interviews with law enforcement, it was learned that the child died at home, and was found by her mother on the couch in the living room where she had been asleep. The child was last seen alive by the maternal grandfather, prior to him leaving the home, approximately 90 minutes before being found unresponsive by the mother. The mother contacted 911 and began CPR until law enforcement and EMS arrived and took over life saving interventions. The child was pronounced dead upon her arrival at the hospital. The mother agreed to a safety plan to not be alone with the surviving siblings following the initial response by SCDSS.

An autopsy was performed which identified concerns for chronic neglect of the child. The child had ulcers on her buttocks and heels, long finger and toe nails, redness and irritation at her G-tube site, extreme dehydration, and a breakdown of the anal membrane with pockets of puss present indicating that the child did not have regular personal care performed by caregivers. The final autopsy report identified the cause of death as malnutrition from neglect and the manner of death was identified as homicide.

Following the preliminary autopsy report from the medical examiner, SCDSS sought and was granted Article 10 custody of the surviving siblings in family court. The surviving siblings were placed in foster care and remained there through the investigation period.

SCDSS conducted their investigation according to regulatory requirements and gathered information on the child's death through familial and collateral contacts. The child had not been in school since March 2020 due to the COVID-19 shut down. The child received multiple services at school which were not being provided by the mother from March until her death. The child had been in the sole care and custody of the mother at the time of her death due to malnutrition. SCDSS

substantiated the allegations against the mother in accordance with the evidence gathered and the surviving siblings were placed in foster care. The case was opened for long term services in congruence with court proceedings.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The investigation by SCDSS met regulatory requirements and the determination of the allegations was made in accordance with the evidence gathered.

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:
The investigation was conducted according to regulatory requirements.

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: 12/26/2020 **Time of Death:** 01:34 PM

Time of fatal incident, if different than time of death: 12:56 PM

County where fatality incident occurred: St. Lawrence
Was 911 or local emergency number called? Yes
Time of Call: 12:56 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? No - but needed
At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

- ☒ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	10 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Deceased Child's Household	Sibling	No Role	Male	13 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Other Household 1	Father	No Role	Male	39 Year(s)
Other Household 2	Other Adult - BF to 4 and 6-year-old SSs	No Role	Male	43 Year(s)
Other Household 3	Other Adult - BF to 15-year-old SS	No Role	Male	37 Year(s)

LDSS Response

The SC died during an open investigation that began on 12/1/20 concerning EdN for the SSs. SCDSS notified OCFS of the child's death through an OCFS Agency Reporting Form on 12/26/20 and at that time, after interviewing LE, EMS and the family, SCDSS did not have concerns the child died because of abuse or maltreatment. On 12/29/20, an SCR report was received regarding the death. Safety of the SC and SSs was assessed upon receipt of the 12/1/2020 SCR report. Initial

safety was assessed through a home visit to the home. Due to a possible COVID-19 exposure and pending test result, the children were observed from the door and no concerns were noted for them. From the door, the home was observed to be cluttered; however, free of health and safety concerns. A follow up visit was conducted virtually prior to the death of the SC in which no concerns for the children were noted. No additional collateral contacts or in-person interviews were conducted by SCDSS to assess the overall safety of the children or condition of the home prior to the SC's death. The investigation had focused solely on the existing allegations of Educational Neglect for the siblings and no other health or safety factors were assessed.

LE and EMS said the grandfather (MGF) was the last adult to see the SC alive before he left the home and he did not have information regarding the death. EMS reported the home had a foul odor and there were dog feces on the floors. The couch where the SC was asleep was saturated in feces and bodily fluids. The SC's body and G-tube were unkempt and dirty, and she had ulcers about her body.

The SM said the SC required feedings through a G-tube every two hours during the day and had very limited mobility. The SM slept in on 12/26/20 and the MGF was with the SC the morning of the death. The SM stated that one of the SSs shut the SC's feeding tube off around 12:00 AM and the SM turned it back on around 3:30 AM. The SM shut it off again at 6:00 AM and the SC was asleep at that time. Around 12:00 PM, the SM went to the couch and noticed that the SC's stomach appeared bloated, and she did not look right. The SM called 911 and began CPR. EMS arrived and took over CPR and transported the SC to the hospital. A safety plan was put in place to prevent the SSs from being in the sole care of the SM.

The SSs were forensically interviewed by SCDSS and LE. There were no concerns identified through the interviews and the SSs displayed little knowledge of the fatal incident.

The autopsy showed the SC suffered from dehydration, had neglected finger and toenails, ulcers on the buttocks, and a breakdown of the anal membrane with masses of puss that formed from not being cleaned or changed on a regular basis. The cause of death was malnutrition from neglect and the manner was homicide.

SCDSS interviewed school staff who worked with the SC. The SC had not physically been in school since March 2020. The school district had attempted distance and virtual learning and services with the SM and SC; however, the services were unsuccessful. In school, the SC received physical therapy, occupational therapy, personal hygiene care, and often had her position changed to prevent sores from developing. There were no education or special education services provided to the SC for the 2020-2021 school year prior to her death. A school staff member visited the home on 12/22/20 to deliver holiday gifts to the family. She disclosed a concern that the SC looked thin, but that the SM said the feeding schedule had changed. No other concerns were identified for the SC.

The SM was interviewed again by SCDSS regarding the findings of the preliminary autopsy. The SM said she changed the SC at every feeding, before bed and first thing in the morning. Feeding was prescribed to be every 2 hours during the day, and continuous feeding at night. The SM confirmed the previously reported timeline for the feeding tube being turned on and off the night before the fatal incident. The record did not reflect why the SM turned off the machine when the prescribed feeding was to be continuous overnight.

The BF was interviewed and noted several concerns for the SC in the care of the SM and that he had expressed them to SCDSS previously. Services were offered in relation to the death of the SC. The BF was explored as a placement option and due to housing concerns was not a viable option. The BF of the 6-year-old and 4-year-old SSs was also deemed an inappropriate resource for placement.

Prior to her death, the SC had been receiving services through a non-CPS contracted agency to assist with the management of her medical needs. The agency and care manager assigned to the family aided the SM and SC with appointment scheduling, ensuring prescriptions were refilled and feeding supplies were in stock in the home. This service provider last

met with the family in November 2020 and no concerns were identified for the physical condition of the SC.

SCDSS documented that in the pediatrician's records, a referral for a home health aide was made on behalf of the SC in March 2020 at an appointment to observe pressure sores that were healing. The mother and care manager denied following up with the referral. It was unclear if the care manager was aware the referral had been made or if the SM was receptive to the service coming in the home to provide care. A follow up appointment was conducted via telemedicine with the family in May 2020 to review the healing of the pressure sores the SC previously had been seen for. The pediatrician informed SCDSS that during that appointment the SM stated the SC's pressure ulcers had healed and she had no other concerns; the pediatrician did not observe the ulcers during this appointment. The pediatrician stated this was peculiar for the SM, as she normally expressed a concern for the SC in every previous appointment. The SC's weight was not checked during this telemedicine appointment despite previous concerns for her weight loss. At the last appointment in which the SC was weighed in March 2020, she had gained a pound after losing a significant amount of weight in the 6 months prior to that appointment. No other follow up appointment occurred with the SC before her death.

Following the second interview of the SM, and with the information disclosed by the ME, SCDSS filed for Article 10 custody of the SSs in family court. The order was granted, and the SSs were placed in foster care.

SCDSS conducted their investigation in accordance with regulatory requirements and substantiated the allegations against the SM based on the evidence gathered. The SC's death was ruled a homicide due to chronic neglect and the SC was in the care of the SM for the 9 months prior to her death.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: St. Lawrence County has an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056301 - Deceased Child, Female, 10 Year(s)	057193 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
056301 - Deceased Child, Female, 10 Year(s)	057193 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
056301 - Deceased Child, Female, 10 Year(s)	057193 - Mother, Female, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
056301 - Deceased Child, Female, 10 Year(s)	057193 - Mother, Female, 33 Year(s)	Internal Injuries	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?	☒	☐	☐	☐

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:
Risk of the SSs was assessed throughout the investigation. A determination was made that the SSs were at significant risk in the care of the SM and a petition was filed in family court to remove the children from the care of the SM.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
Initially, a safety plan was agreed to that did not allow the SM to be alone with the SSs. As additional information regarding the death of the SC became known to SCDSS, the children were removed from the care of the SM through family court.

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:**
12/31/2020	There was not a fact finding	There was not a disposition
Respondent:	057193 Mother Female 33 Year(s)	
Comments:	An Article 10 petition was filed in court and the removal of the surviving children from the custody of the mother and placement into foster care was approved by the court.	

Have any Orders of Protection been issued? Yes	
From: 12/31/2020	**To:** Unknown

Explain:
Orders of protection were issued on behalf of the SSs against the SM at the time the SSs were placed in foster care.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐	☐
Health care	☒	☐	☐	☐	☐	☐	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
Services were put in place to assist the SSs in dealing with the death of the SC and to address needs identified when the children were placed in foster care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother accepted and was compliant in services offered and mandated following the placement of the SSs into foster care.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
Were there any siblings ever placed outside of the home prior to this child's death? 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)
12/01/2020	Sibling, Male, 13 Years	Mother, Female, 33 Years	Educational Neglect	Substantiated	Yes
	Deceased Child, Female, 10 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 10 Years	Mother, Female, 33 Years	Lack of Medical Care	Substantiated	
	Sibling, Male, 10 Years	Mother, Female, 33 Years	Educational Neglect	Substantiated	
	Sibling, Male, 10 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 15 Years	Mother, Female, 33 Years	Educational Neglect	Substantiated	
	Sibling, Female, 12 Years	Mother, Female, 33 Years	Educational Neglect	Substantiated	
	Sibling, Male, 6 Years	Mother, Female, 33 Years	Educational Neglect	Substantiated	
	Sibling, Male, 4 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report was received with concerns for educational neglect of the 14-year-old, 13-year-old, 11-year-old, 10-year-old, and 6-year-old SSs. Each SS was failing as a result of their excessive absences. The 10-year-old SC and 4-year-old SS had unknown roles. A subsequent report was received on 12/29/2020 regarding the death of the SC, and allegations were added.

Report Determination: Indicated | **Date of Determination:** 05/17/2021

Basis for Determination:
SCDSS gathered information in relation to the allegations and identified that the children missed excessive days of school during remote learning. Following the death of the SC, the SSs were removed from the care of the mother and placed in foster care. The investigation was closed and opened for long term services.

OCFS Review Results:
SCDSS met regulatory requirements in the investigation of the allegations. The family was under quarantine for COVID-19 related exposures at the time the investigation was initiated. Following the initial home visit, a video visit was held to

check in with the family and no concerns were observed. The SSs were placed in foster care after the concerns for chronic neglect of the SC were discovered during her autopsy. The SSs were assessed as safe in foster care throughout the investigation period.

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

Issue:
Appropriateness of allegation determination

Summary:
SCDSS unsubstantiated the allegation of Inadequate Food, Clothing, Shelter against the SM regarding the SC. Evidence gathered supported that the allegation be substantiated as they directly pertained to the SC's death.

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/21/2020	Sibling, Male, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 5 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 4 Years	Mother's Partner, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 4 Years	Mother's Partner, Male, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report was received that identified concerns that the parent substitute had a history of being sexually inappropriate with children and the SM allowed him to reside in the home. Concerns were also identified for drug use by the SM and PS and stated they were unable to provide adequate care of the children as a result of the substance use.

Report Determination: Unfounded | **Date of Determination:** 07/29/2020

Basis for Determination:
SCDSS met with all family members and interviewed all of the children. There were no concerns for sexual abuse or drug use disclosed by the children during their interviews. The SM disclosed regular marijuana use to SCDSS. It was determined the alleged PS did not live in New York and had never been a person legally responsible for the children.

OCFS Review Results:
The investigation by SCDSS met regulatory requirements. Familial and collateral interviews were conducted and evidence relevant to the allegations was gathered. Biological fathers were notified of the investigation and added to the case composition. Based on evidence gathered, the allegations were unsubstantiated.

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)

12/12/2019	Sibling, Male, 13 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 13 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 10 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 9 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 9 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 9 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 9 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 5 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 11 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 11 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 13 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Emotional Neglect	Unsubstantiated	
	Sibling, Male, 11 Years	Other Adult - BF to 6 and 4 year old SSs, Male, 42 Years	Emotional Neglect	Unsubstantiated	
	Sibling, Male, 13 Years	Mother, Female, 38 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 13 Years	Mother, Female, 38 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged that the PS was frequently intoxicated and became physically and verbally aggressive towards the SM in the presence of the children. As a result of the violence, the 13-year-old and 12-year-old siblings both experienced suicidal ideation. The report also identified concerns for the 13-year-old's attendance in school. The mother was aware of the concerns and failed to intervene.

Report Determination: Unfounded | **Date of Determination:** 04/10/2020

Basis for Determination:
SCDSS met with all family members and obtained relevant collateral information. It was determined the PS was the BF of the 5 and 3-year-old siblings. The SM and PS confirmed a physical altercation occurred and that the children were not present at the time. The SM enrolled the 13-year-old SS in home school and there were no further concerns for attendance at the time the investigation closed. The PS enrolled in chemical dependency counseling and was not using alcohol during the investigation period.

OCFS Review Results:
SCDSS met regulatory requirements in their investigation into the allegations. Based on information gathered through

familial and collateral contacts, there was no evidence present to substantiate the allegations of physical and verbal altercations in the home and the 13-year-old sibling had been enrolled in home school.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/02/2018	Sibling, Male, 10 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 10 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged that the PS was a Level II sex offender residing in the home. The SM was aware of the PS's status as a sex offender and allowed him to be around the children. Further details were unknown.

Report Determination: Unfounded **Date of Determination:** 02/25/2019

Basis for Determination:
SCDSS had investigated similar allegations against the PS previously and were aware of his status as a sex offender. The PS had no stipulations restricting his access to be around the children in the home. The children were interviewed and disclosed no interactions of concern. Collateral information was gathered and a determination was made based on the evidence collected.

OCFS Review Results:
SCDSS met regulatory requirements in conducting their investigation and a determination of the allegations was made based on the evidence gathered through interviews and collateral information.

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)
08/09/2018	Sibling, Male, 12 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 12 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 8 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 8 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 8 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Male, 3 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 2 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 2 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 10 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 10 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 12 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 12 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 9 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 9 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Female, 8 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 8 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 8 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 8 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 3 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 2 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 2 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 10 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 10 Years	Other Adult - BF to 6 and 4 year old siblings, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
The SCR report alleged that the SM and PS smoked marijuana and drank alcohol in the presence of the children on a daily basis. The SM and PS also engaged in physically violent altercations in the presence of the children. The 11-year-old sibling was kicked by the PS three weeks prior and required crutches to treat his injury. The PS was verbally abusive towards the children.

Report Determination: Unfounded | **Date of Determination:** 02/01/2019

Basis for Determination:
SCDSS initiated their investigation into the allegations upon receipt of the report. It was learned the 11-year-old SS broke

a window in the home, sustaining the injury reported. The injury was not a result of violence from the PS. The SM admitted to regular marijuana use, though not in the presence of the children. There were no concerns of violence reported in the home through familial and collateral contacts.

OCFS Review Results:
SCDSS met regulatory requirements when conducting their investigation into the allegations reported. The safety of the children was assessed throughout the investigation period and there were no concerns of drug use or physical violence disclosed. The family remained open through a subsequent report and this investigation was closed.

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

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

There have been 22 investigations involving the family dating back to 2010 which included the children being placed in foster care twice. A total of 10 investigations were substantiated. Overall allegations of investigations involved the parents failing to follow through with medical concerns for the SC and her siblings, the father's use of physical discipline and anger issues, the conditions of the home, and alleged drug and alcohol abuse occurring in the home.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Foster Care Placement History

The children were placed in foster care from 9/7/10-11/5/10 and returned to the care of the parents. The children were again placed in foster care on 5/1/15. While some of the SSs were returned to the care of the SM, the SC remained in foster care until 3/13/18 at which time she was returned to the care of the SM. The SC remained in care due to the SM's inability to care for the SC due to her multiple medical needs. While the children were in foster care the family participated in prevention services which included court ordered services, community based waiver services, and mental health services. The family completed serviced and had the children returned to their care.

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