Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-23-015

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

Issue Date: Aug 22, 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 **Jurisdiction:** Oneida **Date of Death:** 03/07/2023
Age: 13 year(s) **Gender:** Female **Initial Date OCFS Notified:** 03/07/2023

Presenting Information

On 3/4/23, Oneida County Department of Social Services (OCDSS) was notified by hospital staff, that the 13-year-old female subject child (SC) was admitted to the hospital on 3/4/23 after being hit by a car and suffered a brain injury. The subject child died at the hospital on 3/7/23. There was an open CPS investigation at the time of the death, which began on 2/13/23. OCDSS notified the Syracuse Regional Office of the death via the OCFS 7065 Agency Reporting Form.

Executive Summary

This report concerns the death of the subject child which occurred on 3/7/23. At the time of the fatality, the child resided with her mother, stepfather, twin 11-year-old siblings, and 5-year-old sibling. OCDSS assessed the siblings to be safe in the care of the mother and stepfather. The record did not reflect OCDSS made any contact with the father of the child and siblings.

Upon learning of the incident, OCDSS gathered information from the hospital staff and the mother. It was learned that on 3/4/23, the child was walking with two friends on an unlit back road at about 7:00 PM and was struck by a car. EMS responded to the scene and transported the child to the hospital. The child remained unresponsive to stimuli after the crash. Hospital staff performed brain death testing that confirmed the child had no brain activity and brain death was declared. The family consented to organ donation. The child was pronounced deceased on 3/7/23 at 6:31 AM, at the hospital.

At the time of the fatality, OCDSS had an open and ongoing investigation with the family pursuant to an SCR report received on 2/13/23 regarding one of the 11-year-old twin siblings being made to stand in a corner for eight hours as a form of punishment by the stepfather. There was no SCR report regarding the death, as OCDSS gathered information and determined there was no reason to suspect abuse or maltreatment by the mother or stepfather led to the death of the child.

OCDSS contacted the medical examiner’s office, and an autopsy was performed. The final autopsy report stated the cause of death was “Multiple Blunt Force Injuries due to Pedestrian struck by car” and the manner of death was accident. The child had upper and lower extremity trauma and the point of probable impact was the posterior right thigh/knee. The subject child had scalp hemorrhages and bleeding in the membranes covering the brain. The subject child’s toxicology was positive for cannabinoids. Law enforcement investigated the death and found no culpability on the part of the mother and stepfather. The driver of the vehicle was not charged criminally, and the incident was considered an accident.

OCDSS gave the mother a list of community-based bereavement resources and referred the family for a preventive services case. The mother enrolled the twin siblings in grief counseling. OCDSS appropriately investigated the death of the child; however, the CPS investigation remained ongoing at the time this report was written.

PIP Requirement

OCDSS will submit a PIP to the Syracuse 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, ODCSS 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
The fatality was not SCR reported; therefore, certain assessments were not required.

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 open CPS investigation at the time of the death remained ongoing at the time this report was written.

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: 03/07/2023 **Time of Death:** 06:31 AM

Date of fatal incident, if different than date of death: 03/04/2023
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Oneida
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: Walking home with friends

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	No Role	Female	13 Year(s)
Deceased Child's Household	Mother	No Role	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Stepfather	No Role	Male	36 Year(s)
Other Household 1	Father	No Role	Male	35 Year(s)

LDSS Response

OCDSS had an open investigation at the time of the fatality. The case was opened on 2/13/23, regarding concerns that the stepfather made one of the twin siblings stand in the corner for 8 hours. Upon notice of the death, OCDSS completed the required 7065 Agency Reporting Form timely, assessed the safety of the siblings, spoke with hospital staff, and interviewed the mother and siblings. The record did not reflect the stepfather was seen or interviewed regarding the death of the SC.

OCDSS interviewed the mother on 3/7/23, and learned on the day of the fatal incident 3/4/23, the SC had called the mother to pick her up at a friend’s home; however, the mother’s car was not working properly, and the mother told the SC to walk to the MGM’s home. The family was staying with the MGM while in the process of moving to a new apartment. The mother was aware the SC and her friends often walked to each other’s houses, and she had no concern for the SC walking to the MGM’s home. The mother said there was a witness that saw the SC and her friends walking in the middle of the road and they were wearing dark clothing. The mother was aware the SC was using marijuana; however, she did not consent to the use and never supplied the SC with it.

OCDSS assessed the safety of the twin siblings and the 5yo sibling on 3/7/23, after the death of the SC. While the mother was at the hospital the twin siblings were with the MGM and the 5yo sibling was with the MGF. OCDSS completed a home visit to the MGM’s home and interviewed the twin SSs. The twin siblings said they just sat down for dinner and heard the mother on the phone with the SC; however, they could not remember if the mother told the SC to wait or walk home. The 5yo sibling was seen and interviewed at the MGF’s home, she had no information regarding the fatal incident. The SSs were assessed as safe and appeared well with no visible marks or bruises.

The open CPS investigation remained ongoing at the time this report was written. The mother agreed to a services case and OCDSS referred the family for preventive services.

Official Manner and Cause of Death

Official Manner: Accident
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 referred to an OCFS approved Child Fatality Review Team? Yes

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
This was not an SCR reported fatality; therefore, certain investigative activities were not required. OCDSS did investigate the circumstances surrounding the subject child's death.

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?	☐	☒	☐	☐

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐

Explain:
As there was no SCR report surrounding the fatality, the completion of safety assessments were not required; however, OCDSS documented an assessment of the siblings' safety following the death and there were no concerns.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☐	☒	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☐	☐	☒	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
The case remained open at the time this report was written and the RAP was not yet completed.

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

Additional information, if necessary:
OCDSS made a referral for preventive services for the family following the death of the child. The mother enrolled the twin siblings in counseling services; however, the record did not reflect if the CHN engaged with the services. The record did not reflect OCDSS offered burial assistance to the mother or any services to the father.

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:
OCDSS offered the mother services regarding the siblings, and the mother accepted.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS offered the mother bereavement and preventive services, and the mother accepted. The record did not reflect OCDSS offered the mother burial assistance.

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)
02/13/2023	Sibling, Female, 11 Years	Mother, Female, 26 Years	Inadequate Guardianship	Pending	Yes
	Sibling, Female, 11 Years	Stepfather, Male, 26 Years	Inadequate Guardianship	Pending	

Report Summary:
An SCR report alleged on 2/12/23 for unknown reasons the stepfather made one of the 11yo twin siblings stand in the corner for 8 hours. The mother was aware and failed to intervene. The role of the father was unknown.

Report Determination: Undetermined

OCFS Review Results:
Written notice was not provided timely. The record reflected OCDSS assessed the safety of the children timely; however, the 7-day safety assessment was completed 3 days late. A home visit was made, the children were all seen and interviewed. The record did not reflect the father of the SC and SSs was seen or interviewed regarding the report.

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

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

Summary:
The record did not reflect OCDSS made diligent efforts to locate, interview, or notify the father of the children listed on the report.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/02/2022	Sibling, Female, 10 Years	Stepfather, Male, 36 Years	Excessive Corporal Punishment	Pending	Yes
	Sibling, Female, 10 Years	Stepfather, Male, 36 Years	Inadequate Guardianship	Pending	
	Deceased Child, Female, 12 Years	Stepfather, Male, 36 Years	Inadequate Guardianship	Pending	
	Sibling, Female, 10 Years	Stepfather, Male, 36 Years	Inadequate Guardianship	Pending	
	Sibling, Female, 4 Years	Stepfather, Male, 36 Years	Inadequate Guardianship	Pending	
	Deceased Child, Female, 12 Years	Mother, Female, 36 Years	Inadequate Guardianship	Pending	

Deceased Child, Female, 12 Years	Mother, Female, 36 Years	Lack of Medical Care	Pending
Deceased Child, Female, 12 Years	Mother, Female, 36 Years	Sexual Abuse	Pending

Report Summary:
An SCR report dated 11/2/22, alleged the stepfather and SC got into an argument and the stepfather threatened to drag the SC by the hair when she refused to get into the car. The SC ran off from the stepfather and when she returned home the stepfather locked the door and did not allow the SC in the home. The stepfather did not make plan for the SC's care. As a result, the SC was alone outside in the community until 1:00AM, when she went to a friend's residence. On 11/28/22, a subsequent SCR report alleged the stepfather hit the SM in the presence of the children. One to two times a week one of the twin SSs was made to stand in a corner, facing the wall, for 30-60 minutes with both hands on the wall as punishment. On 12/13/22, a subsequent SCR report alleged the SM was unable to control the SC, she often ran away from home, and the SM was unaware of the SC's whereabouts. The SM was aware the SC was sexually active. As a result, the SC had a pelvic inflammation, and there were concerns that she had a Sexually Transmitted Infection. The SM failed to address the issues regarding the SC's sexual activities. As a result, the child continued to engage in sexual acts. The SC left a medical exam without receiving adequate medical care. The mother failed to intervene and as a result, the SC was at risk of a more serious infection and her condition worsening. The SCR reports dated 11/28/22 and 12/13/22 were consolidated into the 11/2/22 report.

Report Determination: Undetermined

OCFS Review Results:
Written notice was provided untimely. The record did not reflect the mother was offered services regarding the SC's behaviors. The record did not reflect the stepfather was seen or interviewed regarding the 11/28/22 report. The stepfather was seen regarding the 12/23/22 report; however, the record reflected he was only asked RAP questions. The report did not reflect the father of the SC and siblings was notified, seen, or interviewed. The investigation ran concurrently with other subsequent reports that were unable to be consolidated; however, the record did not reflect why this investigation remains open.

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

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

Summary:
The record did not reflect OCDSS made efforts to locate, interview, or notify the father of the SC and siblings, that was listed on the report. The stepfather was not seen or interviewed regarding the allegations in the 11/28/22 report and the report reflected he was only asked RAP questions regarding the 12/13/22 report.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:
Failure to Offer Appropriate Services

Summary:
The mother reported ongoing concerns regarding the SC's behaviors during the investigation. The SC was suspended from school, leaving the home without permission, and engaged in unsafe behaviors. The record did not reflect the mother was offered services or referred to any community-based services.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation conducted, OCDSS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/22/2022	Deceased Child, Female, 12 Years	Mother, Female, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Deceased Child, Female, 12 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 12 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 12 Years	Stepfather, Male, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 12 Years	Stepfather, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 12 Years	Stepfather, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 10 Years	Stepfather, Male, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 10 Years	Stepfather, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Stepfather, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 10 Years	Stepfather, Male, 36	Inadequate Food / Clothing /	Unsubstantiated	

	Years	Shelter	
Sibling, Female, 10 Years	Stepfather, Male, 36 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 10 Years	Stepfather, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 4 Years	Stepfather, Male, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 4 Years	Stepfather, Male, 36 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 4 Years	Stepfather, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged the stepfather's home was in an unsanitary condition that was a health hazard to the unknown number of children in the home. The home was infested with roaches and fleas. The stepfather failed to clean the home adequately and failed to allow service providers access to the home to eradicate the infestation. A subsequent report was received on 9/19/23, that alleged the home was infested with cockroaches and the family had to throw all the furniture away. The adults in the home abused methamphetamines while the children were in the home. The stepfather went on a tirade with a baseball bat, bashed in a trash can, and threatened neighbors.

Report Determination: Unfounded | **Date of Determination:** 07/10/2023

Basis for Determination:
The allegations of IG and IF/C/S were unsubstantiated against the stepfather and mother regarding the SC and SSs. Home visits were made, and the family was actively addressing the infestation concerns and the home was not considered a health hazard to the children. The allegation of PD/AM against the stepfather was unsubstantiated. The stepfather and mother were drug tested and were negative for substances other than marijuana. The parents agreed to have a sober caretaker for the children.

OCFS Review Results:
The record reflected timely completion of case objectives including the investigation initiation, 7-day Safety Assessment, provision of notification letters, and check of CPS history. The investigation ran concurrently with other subsequent reports that were unable to be consolidated; however, the record did not reflect why this investigation remained open until 7/10/23, while the subsequent reports were being addressed.

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)
12/14/2021	Sibling, Female, 17 Years	Father, Male, 33 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 17 Years	Father, Male, 33 Years	Sexual Abuse	Substantiated	
	Deceased Child, Female, 11 Years	Father, Male, 33 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 11 Years	Father, Male, 33 Years	Sexual Abuse	Unsubstantiated	

Report Summary:
An SCR report alleged the father sexually abused the then 17yo SS and the SC. When the then 17yo SS was 14 years old, the father inappropriately touched her and checked her vagina to determine if she was still a virgin. When the SC was 7 years old, the father touched her in a sexual manner and often walked in on her when she was in the bathroom or

bedroom and watched the SC get dressed and undressed. The father's actions made the SC uncomfortable.

Report Determination: Indicated	**Date of Determination:** 08/31/2022

Basis for Determination:
OCDSS substantiated the allegations of IG and SA against the father regarding the then 17yo SS. The SA was investigated in 2018, and an order of protection was in place against the father regarding the SS. OCDSS substantiated the allegation of IG against the father regarding the SC due to the risk of harm to the SC. The allegation of SA against the father regarding the SC was unsubstantiated. OCDSS found the father's behaviors were inappropriate; however, no criminal charges were filed against the father. LE was unable to establish the father's actions were done for sexual gratification. The father refused to be interviewed. The mother obtained full custody of the children.

OCFS Review Results:
Written notice was provided timely. The 7-day safety assessment was done and approved untimely. A CPS history check was completed for the family. A home visit was made, and collaterals were contacted. The record reflected no casework activity from 2/3/22 to 6/22/22 and 6/23/22 to 8/15/22. The then 17yo sibling was never seen or interviewed regarding the report; although she was listed as an abused child on the report.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-day Safety Assessment was completed and approved 12 days late, on 1/3/22. The 17yo SS and other children listed on the report were not seen or interviewed prior to the safety assessment being completed.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
OCDSS will document and approve all safety assessments within the required timeframe.

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

Summary:
The record did not reflect OCDSS saw or interviewed the then 17yo SS, that was listed as an abused child on the report. The younger siblings listed on the report were not seen or interviewed until 8/15/22, and were not asked key safety/risk questions.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDSS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of the inter-relatedness of risk influences and individual risk elements affecting family functioning The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

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

Summary:
There was a predetermination of safety and risk as the record did not reflect there was casework activity from 2/3/22 to 6/22/22 and 6/23/22 to 8/15/22. The record reflected the younger siblings were never seen or interviewed regarding the report until 8/15/22. OCDSS had concerns regarding the cleanliness of the home and an ongoing bug infestation.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/16/2021	Sibling, Female, 16 Years	Mother, Female, 34 Years	Childs Drug / Alcohol Use	Unsubstantiated	Yes
	Sibling, Female, 16 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 11 Years	Father, Male, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 16 Years	Father, Male, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 11 Years	Mother, Female, 34 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Deceased Child, Female, 11 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the father was physically aggressive toward the mother while the SC and the then 16yo SS were present. The mother smoked marijuana daily, provided the 16yo SS with marijuana and allowed her to engage in the drug use. The 16yo SS provided the marijuana to the SC and the mother failed to intervene.

Report Determination: Unfounded | **Date of Determination:** 10/04/2021

Basis for Determination:
The allegations of IG and CDRG were unsubstantiated against the SM regarding the SC and the then 16yo SS. The allegation of IG was unsubstantiated against the father regarding the SC and 16yo SS. OCDSS found no credible evidence to support the allegations. The family was seen and interviewed. The SM denied she gave the SC and 16yo SS marijuana or allowed them to use any drugs. The SM denied using marijuana while caring for or in the presence of the children. The 16yo SS and the SC denied marijuana use. The father was incarcerated at the time the report was closed.

OCFS Review Results:
Written notice was provided timely. The 7-day safety assessment was done and approved timely. A CPS history check was completed for the family. A home visit was made and collaterals were contacted. The record reflected no casework activity from 2/23/21 to 7/24/21 and 7/25/21 to 9/16/21.

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

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

Summary:
There was a predetermination of safety and risk as the record did not reflect there was casework activity from 2/23/21 to 7/24/21 and 7/25/21 to 9/16/21. The record reflected concerns for ongoing domestic violence in the home and the mother's substance misuse while caring for the children.

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.

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

An SCR report dated 6/25/19 was unsubstantiated for the allegations IG against the SM and stepfather regarding the SC and one of the twin siblings.

An SCR report dated 7/8/19 was unsubstantiated for the allegations of IG, IF/C/S, PD/AM against the SM regarding the SC, and the siblings.

An SCR report dated 11/24/18 was unsubstantiated for the allegations IG, IF/C/S, LS, PD/AM against the SM and an unrelated home member and Internal Injuries against the stepfather regarding the SC and the siblings.

An SCR report dated 8/8/2018 was unsubstantiated for the allegations IG and PD/AM against the SM regarding the twin siblings.

An SCR report dated 5/14/18 was substantiated for the allegations of IG against the SM and father regarding the SC, siblings, and a now adult sibling. The allegation of SA against the father was substantiated regarding a now adult sibling. A services case was opened.

An SCR report dated 2/3/17 was unsubstantiated for the allegations of IG and LS against the SM and the father regarding the SC and one of the twin siblings.

An SCR report dated 1/18/17 was unsubstantiated for the allegations IG against the SM and the father regarding the SC and the twin siblings. The allegations of LS, L/B/W, and XCP, were unsubstantiated against the SM and the father regarding the twin siblings.

An SCR report dated 6/24/16 was unsubstantiated for the allegations IG, IF/C/S, and PD/AM against the SM and the father regarding the SC and the twin siblings.

An SCR report dated 5/31/15 was unsubstantiated for the allegations IG and PD/AM against the SM and the father regarding the SC and the twin siblings.

An SCR report dated 9/18/14 was substantiated for the allegations IG against the SM and the father regarding the SC and the twin siblings. The parents admitted to ongoing domestic violence in front of the children and the SC and twin siblings were left in the care of the now adult sibling.

An SCR report dated 4/15/14 was substantiated for the allegations IG, against the SM and the father regarding the SC and twin siblings. A verbal domestic violence incident occurred that turned physical with the father hitting the mother in front of the children and the children were scared.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

8/14/15-11/13/2015
A voluntary family service stage was opened on 8/14/15, for ongoing concerns of domestic violence and drug misuse regarding the mother and the father around the children. The mother declined services and stopped her marijuana use. The

mother agreed to another drug screen that confirmed her levels decreased significantly. The father engaged with mental health counseling and decreased his marijuana use. The parent's relationship improved. The parents requested the services case be closed. OCDSS verified the parents had no domestic violence incidents since the case opened, the father remained active in counseling and was following recommendations. The services case closed on 11/13/2015.

6/22/18-10/30/20
A services case was opened on 6/22/18, regarding the history of ongoing domestic violence between the mother and father. Police responded to the home numerous times for verbal threats, verbal abuse, destroyed property, and hitting/pushing/punching. The children witnessed several of these issues. A stay away order of protection was issued protecting the mother from the father through family court and the mother obtained sole custody of the children. In 2019, the father attempted to sexually abuse a now adult sibling. The father was charged criminally and found guilty of sex abuse 2nd degree regarding the now adult sibling and an order of protection was put in place. The father had supervised visits with the subject child and siblings. At the close of the services case on 10/30/20, the mother and father had no court ordered services, and the father completed probation after being incarcerated. A services case was no longer necessary for the mother to provide a safe and stable environment and meet the physical, emotional, and mental needs of the children.

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.

Additional Local District Comments

Some notes have been entered from SUB reports as well as clarification on others. The father was attempted, 5/2/23. The stepfather was contacted via phone 6/1/23 and seen on 6/5/23. This case will be discussed at CFRT.

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