Child Fatality Report

Report Identification Number: SY-23-025

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

Issue Date: Oct 13, 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: Onondaga
Date of Death: 05/01/2023
Age: 3 year(s)
Gender: Female
Initial Date OCFS Notified: 05/01/2023

Presenting Information

On 5/1/2023, Onondaga County Department of Children and Family Services (OCDCFS) received an SCR report alleging the death of the 3-year-old subject child. Around 2:00 PM that day, the subject child was placed in a crib for a nap by her female guardian (guardian 1). The subject child had a history of climbing out of the crib. At an unknown time, the subject child climbed out of her crib and got stuck between that crib and another crib which was about 6 inches away. Around 4:00 PM, a relative of the guardians found the subject child hanging between the cribs by her neck. The relative called for guardian 1 who contacted contacted emergency medical services. Law enforcement and emergency medical services responded to the home and performed cardiopulmonary resuscitation; however, attempts to resuscitate the subject child were unsuccessful and the subject child was pronounced deceased. A subsequent SCR report was received 5/2/2023, and contained substantively similar allegations.

Executive Summary

This report concerns the death of the 3-year-old subject child which occurred on 5/1/2023. At the time of her death, the subject child resided with her legal guardians, her 6-year-old surviving half-sibling, and the 17, 3, and 2-year-old children of the legal guardians. The subject child had unsupervised public visitation with her father and sporadic supervised visitation with her mother. The 6-year-old surviving half-sibling had no contact with his father. There were 2 other maternal half-siblings who resided with their father. All children were seen face-to-face and assessed to be safe in the care of their respective caregivers.

On 5/1/2023, around 12:30 PM, guardian 1 put the subject child and the 2-year-old other child down for naps in their shared bedroom. Both children were placed to sleep in cribs that were next to each other. Despite her age, the subject child was placed in a crib as she would not sleep in a toddler bed and would attempt to climb into bed with the other children. Shortly after placing the children down for naps, guardian 1 heard the subject child climb out of her crib and begin to play on the floor. Between 1:30 and 2:00 PM, guardian 1 changed the subject child's diaper and placed her back in the crib. Guardian 1 then went to rest in another room. Sometime after 2:30 PM, the guardians' adult daughter and 10-year-old grandchild arrived at the home. The adult daughter sent the grandchild to the children's bedroom to put away a toy and the grandchild observed the subject child stuck between the two cribs. The grandchild screamed for the adult daughter who responded to the bedroom and attempted to dislodge the subject child as she was caught by her neck between the cribs. Guardian 1 responded to the bedroom when she heard the screaming and was able to dislodge the subject child. The adult daughter's paramour had arrived at the home by that time and contacted 911. The 911 operator directed the adults to perform CPR as the subject child was not responsive. Guardian 1 attempted CPR until first responders arrived at the home.

First responders arrived at the home and took over life saving measures; however, the subject child was noted to be cool to the touch with rigidity starting. The subject child was transported to the hospital and further life saving measures were attempted; however, the subject child was declared deceased at 4:50 PM. Emergency medical providers and hospital staff reported the subject child had discoloration to her neck and torso; however, reported no specific concerns for inflicted abuse or trauma to the subject child.

An autopsy was completed, and the medical examiner provided OCDCFS with the final autopsy report. The cause of death was noted to be mechanical asphyxia due to wedging and the manner of death was noted to be accidental. The autopsy report noted discoloration and petechial hemorrhaging related to the fatal incident. Law enforcement noted there

were no charges or arrests and the death appeared to be an unfortunate accident; however, the law enforcement investigation remained pending at the time the CPS investigation was closed.

The allegations of DOA/Fatality, Lacerations/Bruises/Welts, and Inadequate Guardianship were unsubstantiated against the guardians and OCDCFS noted there was not a preponderance of evidence that the subject child's death was the result of abuse or maltreatment.

Fatality related services were offered to the guardians and the children in their household as well as to the mother of the subject child. Services were declined by the father of the maternal half-siblings.

PIP Requirement

For citations identified in historical cases, OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDCFS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDCFS 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?	Yes
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:

Caseworker activity was commensurate with case circumstances.

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: 05/01/2023 **Time of Death:** 04:50 PM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 04:06 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

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

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	3 Year(s)
Deceased Child's Household	Other Adult - Guardian 1	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Other Adult - Guardian 2	Alleged Perpetrator	Male	42 Year(s)
Deceased Child's Household	Other Child - Child of the guardians	No Role	Male	17 Year(s)
Deceased Child's Household	Other Child - Child of the guardians	No Role	Male	3 Year(s)
Deceased Child's Household	Other Child - Child of the guardians	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Other Household 1	Mother	No Role	Female	42 Year(s)
Other Household 2	Father	No Role	Male	46 Year(s)
Other Household 3	Other Adult - Father of the sibling	No Role	Male	38 Year(s)

LDSS Response

Immediately upon receipt of the SCR report, OCDCFS coordinated with law enforcement, interviewed household members, and gathered information from pertinent collaterals. Home visits were completed as appropriate and all children residing in the home as well as siblings of the subject child who resided elsewhere were assessed to be safe in the care of

their caregivers.

Guardian 1 was interviewed at her home and reported she had placed the subject child to sleep in a crib around 12:30 PM on 5/1/2023. Guardian 1 stated it was common practice in their home for the subject child to be placed in a crib for nap time, as the subject child had a habit of leaving her toddler bed and attempting to get into bed with the other children. Guardian 1 stated that had been discussed with the subject child's pediatrician who advised it was fine for the subject child to be placed in a crib even if she was able to climb out of it. Guardian 1 stated the subject child climbed out of the crib sometime after being put down for her nap and she changed the subject child's diaper and placed her back to sleep in the crib between 2:00 and 2:30 PM. Guardian 1 went to rest in another room and was woken when she heard her adult daughter and 10-year-old grandchild yelling in the children's bedroom. Guardian 1 responded to the bedroom and observed the subject child stuck by the neck in between the 2 cribs. Guardian 1 stated she was able to dislodge the subject child and attempted CPR at the direction of the 911 operator.

The guardians' adult daughter and 10-year-old grandchild were interviewed and provided similar details. Both denied concerns for the care of the subject child or other children in the home and stated the guardians were loving and appropriate with all of the children in the home.

Guardian 2 was interviewed and stated he was not present when the incident occurred. Guardian 2 stated the subject child was regularly placed to sleep in the crib due to issues with her not staying in her own bed. Both guardians denied any mental health issues, substance misuse, or violence in the home.

Interviews were completed with all age-appropriate home members as well as the half-siblings who resided outside of the home. There were no concerns disclosed regarding the guardians' care of the subject child or other children in the home.

OCDCFS interviewed the mother of the subject child and provided her with information for bereavement services. Diligent efforts were made to notify and interview the father of the subject child and the father of the 6-year-old half-sibling; however, neither father responded to OCDCFS's attempts at contact.

Information was gathered from appropriate collateral sources including the hospital, first responders, law enforcement, the children's school, the family's service providers, and the subject child's pediatrician. The subject child's pediatrician verified they had advised the family it was fine for the subject child to sleep in a crib due to the concerns for her leaving her toddler bed. All collaterals denied specific concerns for the subject child and other children in the home and stated the guardians were appropriate caregivers.

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 investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: The fatality was referred to Onondaga County's Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065022 - Deceased Child, Female, 3 Yrs	065024 - Other Adult - Guardian 1, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
065022 - Deceased Child, Female, 3 Yrs	065024 - Other Adult - Guardian 1, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
065022 - Deceased Child, Female, 3 Yrs	065024 - Other Adult - Guardian 1, Female, 40 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
065022 - Deceased Child, Female, 3 Yrs	065025 - Other Adult - Guardian 2, Male, 42 Year(s)	DOA / Fatality	Unsubstantiated
065022 - Deceased Child, Female, 3 Yrs	065025 - Other Adult - Guardian 2, Male, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
065022 - Deceased Child, Female, 3 Yrs	065025 - Other Adult - Guardian 2, Male, 42 Year(s)	Lacerations / Bruises / Welts	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	☐	☐	☐	☐	☐	☒	☐

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:
Fatality related services were provided to all children in the family composition.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Fatality related services were offered to all adults in the case composition; however, were declined.

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	Alleged	Alleged	Allegation(s)	Allegation	Compliance

SCR Report	Victim(s)	Perpetrator(s)		Outcome	Issue(s)
08/22/2022	Deceased Child, Female, 2 Years	Father, Male, 46 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 2 Years	Father, Male, 46 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged the father used illegal substances including heroin, pills, and synthetic marijuana while the sole caretaker for the then 2-year-old subject child. The father was unable to adequately care for the subject child when under the influence of substances.

Report Determination: Unfounded

Date of Determination: 11/14/2022

Basis for Determination:
The Investigation Conclusion Narrative noted the subject child had been in kinship foster care for over 2 years at the time the report was received and the foster parents were granted KinGAP guardianship of the subject child and the surviving sibling. The father had been granted unsupervised visits in public and had completed only one such visit at the time of the allegations. The kinship guardian reported no concerns for the father using substances during the unsupervised visit. The father denied any substance use for himself during the visit. The father was on probation and tested negative for illegal substances. The allegations were unsubstantiated.

OCFS Review Results:
OCDCFS initiated a timely investigation upon receipt of the SCR report. OCDCFS assessed the subject child to be safe in the care of the guardian immediately upon receipt of the SCR report and reassessed the safety of the subject child throughout the investigation. The record reflected attempts made to interview the father; however, there was no documented contact or interview with the father. OCDCFS gathered information from the guardian and appropriate collaterals. There was no documented interview or attempted interview with the mother.

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

Issue:
Case record contains information that is relevant, useful, factual and objective

Summary:
The Investigation Conclusion Narrative noted the father denied all of the reported allegations; however, there was no documented contact or interview with the father in the case record.

Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:
OCDCFS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

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

Summary:
The case record reflected there was no face-to-face contact or attempted face-to-face contact with the mother of the subject child.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDCFS will make efforts to make face-to-face contact with a child and/or a child’s parents or guardians and document efforts that were unsuccessful.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/24/2021	Deceased Child, Female, 1 Years	Mother, Female, 40 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 1 Years	Father, Male, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 40 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged that about 1.5 years prior, the mother was positive for heroin and other substances when she gave birth to the subject child. The SCR report also alleged the mother and father had other children removed from their care due to concerns for substance misuse.

Report Determination: Unfounded | **Date of Determination:** 01/04/2022

Basis for Determination:
The Investigation Conclusion Narrative noted neither the mother nor father had unsupervised contact with the subject child at the time of the report. The case record reflected that, while the mother tested positive for illegal substances at the time of the subject child's birth, the subject child tested negative for all substances. All allegations were ubsubstantiated.

OCFS Review Results:
OCDCFS conducted an investigation that met regulatory guidelines. The subject child was seen face-to-face and assessed to be safe in the care of the guardian. OCDCFS interviewed the father face-to-face and documented multiple unsuccessful attempts to contact the mother. Collateral sources were contacted as appropriate. The determination was made in congruence with the information gathered.

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)
01/25/2021	Deceased Child, Female, 1 Years	Other Adult - Adult child of the guardians, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 1 Years	Other Adult - Adult child of the guardians, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 4 Years	Other Adult - Adult child of the guardians, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 4 Years	Other Adult - Adult child of the guardians, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged the guardians' adult child brought the subject child and the sibling to a party at a motel sometime in November of 2020. The guardians' adult child used cocaine in the presence of the children and there was no sober caretaker for the children.

Report Determination: Unfounded | **Date of Determination:** 02/12/2021

Basis for Determination:
The Investigation Conclusion Narrative noted the guardians' adult child did not reside in the home and was not a primary caretaker for the subject child and the sibling. Furthermore, it was found that, while the guardians' adult child did attend a party at a motel, there were no children present. The guardians, subject child, and sibling were open with OCDCFS pursuant to the ongoing foster care case. All collateral contacts denied concerns for the family.

OCFS Review Results:

OCDCFS initiated a timely investigation and made face-to-face contact with the subject child, sibling, guardian 1, and the guardians' adult child. All persons interviewed denied alcohol or other substance use in the presence of the children. The family's ongoing foster care worker disclosed no concerns for the family whatsoever. The biological mother and guardian 2 were listed in the case composition; however, the record reflected no contact or attempted contact with them. The biological fathers of the subject child and sibling were not added to the case composition, nor did the record reflect any attempt to contact them, interview them, or make them aware of the SCR 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 biological mother, the biological fathers of the subject child and sibling, and guardian 2 were not interviewed face-to-face. Other than notification letters mailed to the biological mother and guardian 2, the record did not reflect any attempt to contact or notify the parents regarding the SCR report.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

OCDCFS will make casework contacts per 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.

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

Guardian 1 was listed as a subject on 1 FAR stage and 2 unfounded CPS investigations more than 3 years prior to the fatality regarding both her own children, the subject child, and the surviving sibling. Guardian 2 was listed as a subject on 1 unfounded CPS investigation.

The mother of the subject child had an extensive CPS history more than 3 years prior to the fatality. The mother was listed as a subject on 26 CPS investigations, 13 of which contained allegations substantiated against her. The allegations included Educational Neglect, Lack of Supervision, Inadequate Guardianship, and Lack of Medical Care and there were ongoing concerns for physical violence between the mother and other adults in the presence of the children as well as substance misuse for the mother while she was the sole caretaker of the children.

The father of the subject child was listed as a confirmed subject on 2 CPS reports over 3 years prior to the fatality regarding concerns of substance misuse, lack of supervision, and inappropriate sexual contact towards a child unrelated to this report.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Foster Care Placement History

On 2/4/2019, the mother overdosed while the sole caretaker of the then 2-year-old surviving sibling and 4-year-old other child. The mother was transported to the hospital and tested positive for amphetamines, alcohol, benzodiazepines, and

cannabis. The father was in the home at the time of the incident and also indisposed. The mother consented to the removal of the children. The surviving sibling was placed with guardian 1 on 2/13/2019 and the other child was placed with his biological father. Neglect Petitions were filed against the mother and she was ordered by family court to comply with a mental health evaluation, substance abuse treatment, domestic violence classes, and parent aide classes. The mother did not comply with those orders and had only sporadic visitation with the children.

The subject child was born premature and was placed with the guardians upon her discharge from the hospital on 1/13/2020, as the mother had made no progress with her court orders.

A Neglect Petition had been filed against the father as well, but was withdrawn on 12/3/2021. The father was granted unsupervised public visitation with the subject child which occurred without issue.

Guardian 1 and guardian 2 were granted KinGAP Guardianship of the subject child and the surviving sibling on 8/11/2022, and the foster care case was closed.

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