Child Fatality Report

Report Identification Number: SY-23-033

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

Issue Date: Dec 28, 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 **<u>only</u>** 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:** Cortland **Date of Death:** 08/01/2023
Age: 2 month(s) **Gender:** Female **Initial Date OCFS Notified:** 08/01/2023

Presenting Information

An SCR report was received on 8/1/23 and alleged at 6:30AM either the mother or the father fed the subject child and put her back to sleep in her crib. Between 8:10AM and 8:15AM, one of the parents checked on the subject child and found her unresponsive in her crib. The subject father performed cardiopulmonary resuscitation on the subject child until emergency medical services arrived. The subject child arrived at the hospital at 9:18AM and hospital staff worked on her until she was pronounced deceased at 10:06AM. The mother and the father had no explanation for the subject child's death.

Executive Summary

This report concerns the death of the 2-month-old female child that occurred on 8/1/23. Cortland County Department of Social Services (CCDSS) received an SCR report and subsequent report on 8/1/23, regarding the fatality. The reports contained allegations of DOA/Fatality and Inadequate Guardianship against the mother and father. At the time of her death, the subject child resided with her mother, father, maternal grandfather and two halfsiblings', ages 11 and 12-years-old. Attempts were made to communicate with the biological father of the two half-siblings and obtain his locating information, but all attempts were unsuccessful. In addition, there were two half-siblings, ages 13 and 14-years-old, who resided outside the home. The 13yo half-sibling resided with her father and the 14yo resided with her mother. CCDSS immediately assessed the safety of the surviving half-siblings and determined they were safe in their mother and father's care.

Through a joint investigation with law enforcement, it was learned on 8/1/23, the subject mother and father awoke around 6:30AM to feed the subject child. After the feeding, the parents kept the subject child in their bed and co-slept with her until they woke a few hours later and found her unresponsive. The maternal grandfather called 911 while the father attempted cardiopulmonary resuscitation until emergency medical services arrived and took over life-saving efforts. The subject child was transported to the hospital where she was pronounced deceased at 10:06AM.

CCDSS communicated with law enforcement and learned there were no criminal charges against the parents. CCDSS received the child's autopsy report and certificate of death from the county coroner and learned the manner of death was accident, caused by suffocation, due to or as a direct consequence of an unsafe sleep environment. The toxicology report revealed the subject child was negative for illicit substances.

The allegations of DOA/Fatality and Inadequate Guardianship against the subject mother and subject father were substantiated. CCDSS found there was a fair preponderance of evidence to support the allegations and the case was closed on 9/14/23. The record reflected CCDSS completed their investigation, required reports and safety assessments timely and accurately. The risk assessment was reflective of case circumstances and several visits were completed with the family.

CCDSS discussed grief counseling, substance abuse services and burial assistance with the mother; however, all services were declined. In addition, CCDSS discussed available services through the local child advocacy center. CCDSS spoke with collaterals including the child's pediatrician, the school district, law enforcement, emergency medical services and several family members.

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:
Cortland County made an appropriate decision to substantiate the allegations based on evidence obtained throughout their investigation.

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:
Casework 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: 08/01/2023 **Time of Death:** 10:06 AM

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

County where fatality incident occurred: Cortland

Was 911 or local emergency number called? Yes
Time of Call: 08:18 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] Other

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	59 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Other Household 1	Other Adult - Biological father of HS's	No Role	Male	35 Year(s)

LDSS Response

CCDSS initiated their investigation within 24 hours of receiving the SCR report and coordinated their efforts with law enforcement. CCDSS contacted the source of the report, reviewed prior CPS history, and promptly notified the County Coroner and District Attorney. CCDSS interviewed the family and assessed safety of the all the surviving half-siblings.

On 8/1/23, LE interviewed the SM regarding the fatality. During her interview, she reported visiting the PGM on 7/31/23, with the SC, SF and the 12yo SS. The family returned home around midnight and upon arrival, the 11yo SS and MGF were at the home. The SC fell asleep during the car ride and the SF took her out of the car and brought her inside laying her in her bassinet. The SF and 12yo SS went to sleep while the SM made food for the 11yo SS. The SM went to lay down at approximately 4:00AM, and at that time, the SC woke and began crying. The SM prepared a 4oz bottle of formula for the SC and the SF fed her. Between 6-7:00AM, the SF's alarm went off, and the SM woke up to make the SC another bottle and the SF his breakfast and coffee. The SM brought the food to the SF and she and the SF fell back to sleep. At approximately 8:00AM, the SM woke to the SF screaming that the SC was not breathing. The SM explained the SC had formula coming from her nose. The SM attempted to call 911 but was having difficulty so the MGF contacted 911 while the SF provided CPR to the SC. The mother denied the SC had any medical issues.

On 8/1/23, LE interviewed the SF regarding the fatality. During his interview, he explained between 6-6:30AM the SC had woken and was fussy. He went to make the SC a bottle and returned to the bed that he shared with the SM. He fed the SC 2ozs of formula, burped her and then gave her two more 2ozs. After the feeding, the SF placed the SC under a blanket between himself and the SM and the parents continued sleeping. Around 8:00AM, the SF's alarm went off and he

immediately got out of bed and changed for the day. While doing this, the SF observed the SC's feet hanging out from under the blanket; he recalled the blanket was over her face and body and she was not moving. The SF explained the SC was in the same place as when they went to bed, and when he pulled the blanket off her, he observed formula coming from her mouth and nose and noted her color was normal. The SF reported the SM attempted to call 911 but was unsuccessful, so the PGF contacted 911 while he attempted CPR until EMS arrived. The SF denied the SC had any medical issues. The SF reported the SC did not regularly sleep in the bed with the parents; she would typically be placed in her bassinet but on 8/1/23, they co-slept "just to cuddle for a little bit."

CCDSS and LE interviewed the 11 and 12-year-old SSs at the local child advocacy center. During their interviews, the siblings' reports were consistent with the events that took place on 7/31/23 and 8/1/23. The siblings denied concerns for drug/alcohol use, physical discipline and domestic violence in the home and reported feeling safe in the care of the SM and SF.

CCDSS and LE interviewed the MGF regarding the fatality. During his interview, he reported waking up to the SM screaming that the SC was not breathing. He went into the parents' bedroom and observed the SM was attempting to call 911; however, her phone was not working. He then called 911 and put the phone on speaker so dispatch could provide instructions to the SF on how to perform CPR. The MGF reported the SC slept in a crib but was unaware where she was sleeping at the time of the fatality.

CCDSS communicated with the SC's pediatrician's office and learned the child was last seen on 7/7/23. At the SC's last appointment, she was observed to be healthy. There were no concerns noted for the SC's feedings or indigestion, and no concerns were reported regarding the mother's care of the child.

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: Coroner

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? No
Comments: Cortland County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065768 - Deceased Child, Female, 2 Month(s)	065778 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated
065768 - Deceased Child, Female, 2 Month(s)	065778 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
065768 - Deceased Child, Female, 2 Month(s)	065779 - Father, Male, 38 Year(s)	DOA / Fatality	Substantiated
065768 - Deceased Child, Female, 2 Month(s)	065779 - Father, Male, 38 Year(s)	Inadequate Guardianship	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:
Cortland County provided information for grief counseling and discussed services that were available at the local child advocacy center. In addition, they offered burial assistance and preventive services which the mother declined.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
CCDDS offered alcohol and substance abuse services to the mother due a history of substance use.

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:
Cortland County provided information for grief counseling and discussed services that were available at the local child advocacy center. In addition, preventive services were offered to the family which the mother declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Cortland County provided information for grief counseling and discussed services that were available at the local child advocacy center. Cortland County offered burial assistance and preventive services which the mother 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

Infants Under One Year Old

Infant was born:
☒ With a positive toxicology
☐ With fetal alcohol effects or syndrome
☐ Exhibiting withdrawal symptoms
☐ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/12/2023	Sibling, Female, 14 Years	Other Adult - Mother ,	Inadequate	Unsubstantiated	Yes

	Female, 34 Years	Guardianship	
Other Child - unrelated child, Female, 2 Years	Other Adult - Mother , Female, 34 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 14 Years	Other Adult - OA1, Female, 32 Years	Inadequate Guardianship	Unsubstantiated
Other Child - unrelated child, Female, 2 Years	Other Adult - OA1, Female, 32 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report was received and alleged the mother of the three unrelated children (OA1) ages 12,10, and 3 months old had her children removed from her custody due to substance abuse and neglect. The BM left the 14-year-old SS, and two other children in the care of OA1, knowing she was not an appropriate caregiver and failed to find an alternative plan for their care. When OA1 was caring for the children, she was impaired on substances, mumbling, half asleep and inconsolably crying to the point she could not communicate. This had been an ongoing concern since January 2023.

Report Determination: Unfounded | **Date of Determination:** 06/20/2023

Basis for Determination:
Cayuga County Department of Social Services did not find a fair preponderance of the evidence to support the allegations. During the investigation there were no disclosures that the OA1 was left alone with the children. At case closure the OA1 was no longer living in the home.

OCFS Review Results:
Cayuga County immediately initiated their investigation and spoke to the source of the report. Connections history was reviewed, and notices were provided. Safety assessments were completed timely and accurately; however, the risk assessment was inaccurate. The BM had mental health diagnoses and had history of DV with an active stay away OP in place. The CW provided information for substance abuse services and DV services. The BM was pregnant and safe sleep education/information was not discussed or provided. The biological fathers were added to the report and provided notices; however, there was no attempt to further engage them.

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 fathers were added to the report and notified about the investigation, but there was no effort to interview them.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
Cayuga County will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child, 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.

Issue:
Failure to provide safe sleep education/information

Summary:
The BM was a soon-to-be parent as she was pregnant. There was no safe sleep/education or information provided to the soon to be parents.

Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:

Cayuga County will provide information on safe sleep to the parents and caretakers of infants and parents-to-be whom they encounter.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/09/2023	Deceased Child, Female, 4 Days	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 4 Days	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report was received and alleged on 5/5/23, the SM gave birth to the SC. The SM and the child's toxicology was positive for fentanyl at the time of delivery. Additionally, the SM slept with the child in an unsafe sleeping arrangement on 5/8/23. The SM had the infant in her lap as she and the child slept, and the SM had an open pocketknife in her hand.

Report Determination: Unfounded | **Date of Determination:** 06/26/2023

Basis for Determination:
Cortland County did not find a fair preponderance of the evidence to substantiate the allegations. The SM and SC tested positive for fentanyl at delivery. In addition, the SF and SM tested positive again after completing a drug screen which indicated everyday use. The SM denied any drug use after she gave birth, The SF also denied any drug use claiming the parents' drug screens were tampered with. The siblings denied any concerns for the parents' drug use which provided no evidence of an impact on the children. Cortland County met with their legal department, and it was determined they were unable to take legal action at that time.

OCFS Review Results:
Madison County was initially primary on the SCR report and immediately initiated their investigation and spoke to the source, completed a timely history check, and provided notices. Madison County completed the 7-day safety assessment which was not accurate as safety factor #15 was not selected even though it was applicable as the child had a positive toxicology. The safety plan developed was appropriate. A plan of safe care was completed with the SM and SF, and both were given safe sleep education. Cortland County discussed this case with their legal department and were unable to take legal action. CPS staff attempted to provide preventive services and referrals however the family declined.

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)
12/11/2022	Sibling, Female, 11 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 10 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 11 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 10 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received and alleged the SM and the SF were involved in selling, distributing, and using drugs in the presence of the children. The SM and the SF were selling marijuana, oxycodone, and methamphetamines and left the drugs accessible to the children.

Report Determination: Unfounded | **Date of Determination:** 02/16/2022

Basis for Determination:
Cayuga County did not find a fair preponderance of the evidence to substantiate the allegations. The SM completed an intake appointment for a substance abuse evaluation however did not complete the required drug screen. During the investigation the family moved to Cortland County. Due to the failed efforts to communicate with the family and their

recent move out of county, the family was unable to receive services and the case was closed.

OCFS Review Results:

Cayuga County immediately initiated their investigations and reviewed history. The safety assessments were completed timely and accurately. The Risk Assessment was not completed accurately as the SF was not listed as a secondary caretaker on the Risk Assessment Profile. In addition, the SF was listed as a subject on the report and the allegations of the report were never addressed with him. The investigation determination was completed timely and notification letters were provided.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

No secondary caretaker was identified when it was known that the SF resided in the home, was a subject of the report and had a regular caretaking role for the half-siblings.

Legal Reference:

18 NYCRR 432.2(d)

Action:

Cayuga County will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Issue:

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

Summary:

The SF was listed as a subject on the report; however, there were no attempts to complete a face-to-face interview and address the allegations of the report.

Legal Reference:

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

Action:

A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. 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)
05/17/2022	Sibling, Female, 11 Years	Mother, Female, 33 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Female, 11 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 11 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 11 Years	Father, Male, 37 Years	Educational Neglect	Unsubstantiated	
	Sibling, Female, 11 Years	Father, Male, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 11 Years	Father, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 10	Father, Male, 37 Years	Inadequate Food / Clothing /	Unsubstantiated	

Years		Shelter		
Sibling, Male, 10 Years	Father, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received and alleged the 11yo SS had been absent 26 times and late 30 times, sometimes up to 4 hours late. The 11yo was failing her classes as a result and struggled when present. The parents were aware and failing to address the concern. A subsequent report was received on 6/6/22, and alleged the SM and SF are aware the camper which they live in was a health and safety hazard for the 10yo SS and 11yo SS. There was a hole with a kiddie pool under it for the family to go to the bathroom in. There was no running water or access to plumbing and there was no electric. There were 14 cats at the home. There were hypodermic needles outside the home accessible to the children.

Report Determination: Unfounded | **Date of Determination:** 06/21/2022

Basis for Determination:
Cayuga County did not find a fair preponderance of the evidence to substantiate the allegations. The 11yo had missed several days of school; however, the CW was unable to correlate a negative impact on the SS. Unannounced home visits were completed, and it was determined that there was ample food in the home, there was running water in the camper and there were working toilets. The camper was found to have met minimal standards. The SM, SF and the children were displaced from their residence and the SM planned for the children to stay with their maternal grandfather until stable housing was obtained.

OCFS Review Results:
Cayuga County initiated their investigation within 24 hours, spoke to the source of the report and reviewed prior CPS history. Safety and risk assessments were completed timely and accurately. The investigation determination was completed timely. The record reflected the CW obtained attendance records and spoke with the school regarding the 11yo's grades and attendance. The 11yo was failing all her core classes and missed 36 days. The record lacked follow up with the school district on if SS would be promoted to the next grade and the SM on the reason for the absences. The CW offered the family preventive services which they declined.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
Information was obtained from the school district regarding the 11yo SS current grades and attendance. There was a lack of follow-up on information as to the effect on the child, her current status at the school, and if she would be promoted to the next grade. A determination was made to unfound EdN without all the information to make a determination.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
Cayuga County will make diligent efforts to obtain supporting information from collateral contacts to make an appropriate case determination.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/10/2021	Sibling, Female, 11 Years	Other Adult - OA1, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 11 Years	Other Adult - OA1, Female, 31 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 11 Years	Other Adult - OA1, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Sibling, Male, 10 Years	Other Adult - OA1, Female, 31 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 10 Years	Other Adult - OA1, Female, 31 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 10 Years	Other Adult - OA1, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 11 Years	Other Adult - OA2, Male, 31 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 11 Years	Other Adult - OA2, Male, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 10 Years	Other Adult - OA2, Male, 31 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 10 Years	Other Adult - OA2, Male, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - unrelated child, Male, 12 Years	Other Adult - OA1, Female, 31 Years	Inadequate Guardianship	Substantiated
Other Child - unrelated child, Male, 12 Years	Other Adult - OA1, Female, 31 Years	Lack of Supervision	Substantiated
Other Child - unrelated child, Male, 12 Years	Other Adult - OA1, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Other Child - unrelated child, Male, 10 Years	Other Adult - OA1, Female, 31 Years	Inadequate Guardianship	Substantiated
Other Child - unrelated child, Male, 10 Years	Other Adult - OA1, Female, 31 Years	Lack of Supervision	Substantiated
Other Child - unrelated child, Male, 10 Years	Other Adult - OA1, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Other Child - unrelated child, Female, 3 Months	Other Adult - OA1, Female, 31 Years	Inadequate Guardianship	Substantiated
Other Child - unrelated child, Female, 3 Months	Other Adult - OA1, Female, 31 Years	Lack of Supervision	Substantiated
Other Child - unrelated child, Female, 3 Months	Other Adult - OA1, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Other Child - unrelated child, Male, 12 Years	Other Adult - OA2, Male, 31 Years	Inadequate Guardianship	Substantiated
Other Child - unrelated child, Male, 12 Years	Other Adult - OA2, Male, 31 Years	Lack of Supervision	Substantiated
Other Child - unrelated child, Male, 12 Years	Other Adult - OA2, Male, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Other Child - unrelated child, Male, 10 Years	Other Adult - OA2, Male, 31 Years	Inadequate Guardianship	Substantiated
Other Child - unrelated child, Male, 10 Years	Other Adult - OA2, Male, 31 Years	Lack of Supervision	Substantiated
Other Child - unrelated child, Male, 10 Years	Other Adult - OA2, Male, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Other Child - unrelated child, Female, 3 Months	Other Adult - OA2, Male, 31 Years	Inadequate Guardianship	Substantiated

	Other Child - unrelated child, Female, 3 Months	Other Adult - OA2, Male, 31 Years	Lack of Supervision	Substantiated	
	Other Child - unrelated child, Female, 3 Months	Other Adult - OA2, Male, 31 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report was received and alleged the father of the three unrelated children (OA2) ages 12,10, and 3 months old and the OA1 were selling, distributing, and using drugs in the presence of the children. The OA1 and OA2 sold marijuana, oxycodone, and methamphetamine and left the drugs accessible to the children. In the past the OA1 left paraphernalia on the table next to the children's bed. It was unknown if the children had ever consumed any drugs. The OA1 and the OA2 used oxycodone daily and the OA1 smoked marijuana daily. While under the influence, the OA1 and OA2 were unable to supervise the children. The OA1's behaviors were erratic and changed rapidly and she slept long hours.

Report Determination: Indicated | **Date of Determination:** 02/01/2022

Basis for Determination:
The OA2 admitted to his probation officer that he sniffed pills daily and he had a positive drug screen for amphetamines, benzodiazepine, opiates, and THC. There were ongoing concerns for substance abuse for OA1, evidenced by observations and a recent positive toxicology for opiates regarding the 3-month-old OC. The OA1 failed to follow through with a substance abuse evaluation. There were concerns that the other adults were under the influence while being the sole caretakers of the children. In addition, drug paraphernalia and weapons were found accessible to the children. The 12yo, 9yo and 3-month-old were removed from their parents and an article 10 neglect petition was filed.

OCFS Review Results:
Cayuga County immediately initiated their investigation, spoke to the source of the report, and reviewed prior CPS history. Safety assessments were completed timely and accurately. The risk assessment profile was completed accurately, and all required notifications were provided. The investigation determination was completed timely and accurately. This investigation listed the 11yo and 10yo SSs as maltreated children as the OA1 and OA2 were reported to have cared for the siblings on weekends. The SM and SF were listed on the case as no role, and it was determined the siblings were not cared for by the OA1 or OA2.

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)
07/26/2021	Sibling, Female, 12 Years	Other - Biological mother , Female, 35 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 12 Years	Other - Biological mother , Female, 35 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - unrelated child, Male, 3 Years	Other - Biological mother , Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - unrelated child, Male, 3 Years	Other - Biological mother , Female, 35 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - unrelated child, Female, 6 Months	Other - Biological mother , Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - unrelated child, Female, 6 Months	Other - Biological mother , Female, 35 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report was received and alleged the BM of the 12yo SS, abused methamphetamine while caring for the sibling and two other children ages 3 and 6-month-old. The BM was under the influence of drugs and was caring for the

children.	
Report Determination: Unfounded	**Date of Determination:** 10/03/2021
Basis for Determination: Cayuga County did not find some credible of evidence to substantiate the allegations. Cayuga County and law enforcement conducted a home visit and observed the BM who did not appear to be under the influence at that time. The home was assessed and there were no drugs or paraphernalia observed in the home. Interviews were completed and there were no concerns for drug use reported.	
OCFS Review Results: Cayuga County initiated their investigation within 24 hours, spoke to the source of the report and reviewed CPS History. The safety assessments were completed timely, however; the safety assessment for case closing was labeled incorrectly as CPS 7-day. The Risk Assessment was completed accurately. The record reflected the BM had a recent domestic incident with the father of the 3yo and 6-month-old children; domestic violence services were not discussed with the BM. There were missed opportunities to contact collaterals such as the children's pediatrician, law enforcement, and school district.	
Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No	
Issue: Contact/Information From Reporting/Collateral Source **Summary:** There were missed opportunities to gather collateral information from law enforcement, the school district and the pediatrician. **Legal Reference:** 18 NYCRR 432.2(b)(3)(ii)(b) **Action:** Cayuga County will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.	

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

On 11/1/10, Cayuga County received an SCR report and Sub the allegations of IG and PD/AM against the BM of the 14yo SS. The investigation was closed on 12/21/10.

On 4/13/14, Cayuga County received an SCR report and Unsub the allegation of IG against the BM of the 14yo SS. The investigation was closed on 6/13/14.

On 3/25/16, Cayuga County received an SCR report and Unsub the allegations of OTH/COI-Other against the BM of the 14yo SS and the SF. The case was closed on 4/25/16.

On 5/30/17, Cayuga County received an SCR report and Unsub the allegations of IG and PD/AM against the BM mother of the 14yo SS and the mother's boyfriend. The case was closed on 7/28/2017.

On 11/20/18, Cortland County received an SCR report and Sub the allegation of IG against an unrelated home member (OA2) regarding the two 11 and 13yo SSs. The investigation was closed on 1/30/19.

On 9/16/19, Cortland County received an SCR report and Unsub the allegations of EdN against the SM and SF regarding the 11and 13yo SSs. The investigation was closed on 1/10/20.

On 1/7/20, Cortland County received an SCR report and Unsub the allegations of IG and EdN against the SM regarding

the 13yo SS. In addition, the allegation of IG was Unsub against the SM regarding the 11yo SS. The investigation was closed on 2/25/20.

On 3/11/20, Cortland County received an SCR report and Sub the allegations of EdN against the SM and SF regarding the 13yo SS. The investigation was closed on 5/8/20.

Known CPS History Outside of NYS

The 13yo half-sibling was removed from the SM while residing in Duval County, Florida due to medical neglect and failure to thrive. The sibling remained in foster care for a year until the sibling's father obtained custody. The 13yo half-sibling and the father moved to New York State.

Preventive Services History

In 2010, the SM, 12yo SS and the SS's BF returned to NYS after the SM's involvement with CPS in Florida. On 11/2/10, Tioga County opened a Preventive Services Case for the family due to the SM's out-of-state history. The SM, 12yo SS and the SS's BF then moved to Cortland County. Tioga County sent a referral for services and a case was opened in Cortland County on 1/3/11. The case was opened to assist the SM with supportive services and address prior CPS concerns. The case was closed on 2/28/11.

On 2/14/11, Cayuga County opened a Family Services Stage for the BM of 14yo SS and SF due to concerns for domestic violence, substance abuse and unsanitary conditions within the home. The case was closed on 7/21/11.

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