Child Fatality Report

Report Identification Number: SY-23-044

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

Issue Date: Apr 15, 2024

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 10/25/2023
Initial Date OCFS Notified: 10/25/2023

Presenting Information

An SCR report was received alleging on 10/25/23, at an unknown time, the subject father went to sleep in bed with the 4-month-old subject child. While sleeping, the subject father rolled on top of the subject child. When the subject father woke up at an unknown time, he realized that he was on top of the subject child, and she was unresponsive. The subject father called 911 and emergency medical personnel responded to the home. Emergency medical technicians performed CPR and the subject child was transported to the hospital. The subject child was unable to be revived and at 7:12pm, died as a result of an unsafe sleep situation.

Executive Summary

Onondaga County Department of Children and Family Services (OCDCFS) received an SCR report on 10/25/23, regarding the death of the 4-month-old subject child. The SCR report contained allegations of DOA/Fatality against the subject father regarding the subject child, allegations of Parent's Drug Alcohol Misuse against the subject father regarding the surviving siblings, ages 3 and 2-years-old, and surviving cousins, ages 5, 3, and 2-years-old, allegations of Inadequate Guardianship against the subject father regarding all the children and allegations of Inadequate Guardianship against the subject mother regarding the surviving siblings and the surviving cousins. At the time of her death, the subject child resided with the parents, the surviving siblings, and surviving cousins. Occasionally, the subject father would reside outside of the family’s residence.

OCDCFS was unable to see the surviving children immediately due to the family's tribal mourning customs. However, OCDCFS was able to speak with the subject mother and the paternal uncle to confirm the children were safe.

On 10/30/23, OCDCFS spoke with the subject mother over the phone and learned, on 10/25/23, the subject mother arrived home from work around 6:11PM and found the subject father laying on the bed with the subject child laying in his arms. The subject mother picked the subject child up and noticed something was wrong because the subject child was limp. The subject father sat the subject child up and vomit came out of her nose. The subject father attempted CPR on the subject child. The subject mother attempted to call 911 but hung up due to being emotional. The subject mother's uncle, who lived next door, called 911.

On 1/30/24, OCDCFS received the final autopsy report from the medical examiner. The subject child was pronounced deceased on 10/25/23 at 7:12PM. Official cause of death was unexplained sudden death of infant (intrinsic and extrinsic factors identified) and the manner of death was undetermined. The report noted that the subject child was placed in an unsafe sleep environment, in an adult sized bed and was found with a blanket over her face. At the time of her death, the subject child was positive for SARS-CoV2 (COVID-19) and rhinovirus/enterovirus. The subject child had no sign of injuries.

OCDCFS spoke with law enforcement who reported they were able to access the home before the parents became resistant. The subject father lashed out and refused to speak with them. The information they were able to collect from the family was that the subject father was sleeping with the subject child and the subject mother came home and found the subject child unresponsive. There was no further information about whether or not law enforcement would be making an arrest.

OCDCFS offered the family grief counseling resources and burial assistance, but the subject mother declined. She

reported that she was receiving counseling services through tribal affiliation and before the case was closed, she reported ending the services. The subject mother was connected to a domestic violence advocate through tribal affiliation and in February of 2024 she and the children moved into a domestic violence shelter.

Based on evidence that was gathered during the investigation, OCDCFS appropriately substantiated the allegations of Inadequate Guardianship against the parents and appropriately substantiated the allegations of DOA/Fatality against the subject father. OCDCFS did not gather enough information to make a determination regarding the allegations of Parent's Drug Alcohol Misuse against the subject father.

OCDCFS filed a neglect petition against the parents due to concerns for the subject father's substance misuse and the subject mother continuing to allow him to care for the children. However, the petition was dismissed in Onondaga County Family Court. The court did not have jurisdiction due to the family's tribe affiliation.

PIP Requirement
OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days identifying what actions they have taken, or will take, to address the cited issues. 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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:
OCDCFS did not have enough evidence to substantiate the allegations of PD/AM against the SF regarding the CHN. Enough evidence was gathered to determine the SF misused substances; however, there was nothing to indicate he was using while caring for the CHN or that his misuse negatively impacted the CHN.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:
While the fatality investigation was open OCDCFS opened a preventive services case; however, both cases were closed after OCDCFS's neglect petition was dismissed in Onondaga County Family Court, and the family relocated.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The allegations of PD/AM were substantiated due to information in LE records. The record lacked documentation to support the incidents took place in front of the CHN or that the SF cared for the CHN while under the influence.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	OCDCFS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Syracuse Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/25/2023 **Time of Death:** 07:12 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: Unknown
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

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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Other Child - Cousin	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Other Child - Cousin	Alleged Victim	Male	5 Year(s)
Deceased Child's Household	Other Child - Cousin	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)

LDSS Response

Upon receipt of the SCR report, OCDCFS initiated their investigation within 24 hours and coordinated their efforts with LE. OCDCFS contacted the source, reviewed prior CPS history, and notified the DA and ME.

On 10/26/23, OCDCFS assessed the safety of the SSs and cousins by speaking with the SM and the MU on the phone. Due to the family's tribal custom of having a 10-day mourning period, the SM would not allow OCDCFS to meet with the family until the mourning period was complete. On 11/7/23, OCDCFS met with the family at their home, and it was determined the CHN were safe to remain in the care of the parents. On 11/22/23, OCDCFS told the parents that due to concerns brought to their attention by police reports pertaining to the SF's substance misuse he should not be alone with the CHN.

On 10/30/23 and 11/7/23, OCDCFS spoke with the SM and learned the day of the incident the SC was fine and smiling when the SM went to work at 4:06pm. The SM spoke with the SF around 5:15PM and arrived home on her break around 6:11pm. The SM went upstairs because the SF had said he was going to take a nap. The SF allowed the SC to sleep with him as she was sick. The SM found the SC laying on her side in the SF's arms. The SC appeared normal in color but was lying in a limp fashion. The SM touched the SC's neck and felt nothing, but noticed her nose was warm. The SF sat the SC up and she vomited. The SF began CPR on the SC. The SM attempted to call 911 but she was distraught and hung up. The MU called 911. The SM thought the SC choked on whatever she had thrown up. The SM brought the SC to the ER a week prior to the incident because the SC was sick. The SM planned to bring the SC back to the ER because the SC was still sick. The SM reported she was familiar with safe sleep protocol.

OCDCFS spoke with the SF on 11/7/23. He reported the SC would sleep in her Rock 'N Play, her swing or crib. The day of the incident the SF laid down with the SC in the bed and when he woke, the SC was in his arms and not underneath him. He was unable to say what happened next. He denied being under the influence at the time of the incident. He reported that he had co-slept with all his CHN.

OCDCFS spoke with first responders. One paramedic stated the SF was sleeping with the SC and he rolled over on her and the SC was found face down in the bed. The SC appeared to be blue with snot on her face and she was not breathing. CPR was started and an IV was administered. The parents acted appropriately and appeared to be sober. Another paramedic stated the SM found the SC face down in the bed with the SF's arm around her. He observed the SC being put on a stretcher. He described the SC as being gray, with no signs of trauma and her chest not moving. The SF was making a scene, yelling, screaming and tried to get into the ambulance. He was repeatedly saying he killed his baby, and his baby was dead. The SF was coherent and visibly distraught.

OCDCFS reviewed the hospital records and learned the SC was in cardiac arrest when she arrived at the hospital and CPR had been in progress for about 20 minutes. The SC was pulseless, limp, and blue. CPR was continued in the ER. The SC was pronounced dead at 7:12PM. The SC had been at the ER on 10/18/23 due to being sick. On the day of the incident, the

SC still had a fever but had been eating well and having regular bowl movements.

OCDCFS completed the safety assessments and progress notes timely and accurately. The RAP was completed accurately. OCDCFS contacted LE, medical providers, first responders, the school and was in regular communication with both family's affiliated tribal reservations. OCDCFS gathered police reports regarding the SF's substance misuse and violent behaviors. Although the behaviors were concerning there was a lack of evidence to support how his behaviors directly impacted the CHN; therefore, there was not enough evidence for PD/AM to be substantiated.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066534 - Deceased Child, Female, 4 Month(s)	066536 - Father, Male, 30 Year(s)	DOA / Fatality	Substantiated
066534 - Deceased Child, Female, 4 Month(s)	066536 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
066537 - Sibling, Male, 2 Year(s)	066536 - Father, Male, 30 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
066537 - Sibling, Male, 2 Year(s)	066536 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
066537 - Sibling, Male, 2 Year(s)	066535 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
066538 - Sibling, Female, 3 Year(s)	066536 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
066538 - Sibling, Female, 3 Year(s)	066535 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
066538 - Sibling, Female, 3 Year(s)	066536 - Father, Male, 30 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
066539 - Other Child - Cousin, Male, 2 Year(s)	066535 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
066539 - Other Child - Cousin, Male, 2 Year(s)	066536 - Father, Male, 30 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
066539 - Other Child - Cousin, Male, 2 Year(s)	066536 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
066540 - Other Child - Cousin, Male, 5 Year(s)	066535 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated

066540 - Other Child - Cousin, Male, 5 Year(s)	066536 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
066540 - Other Child - Cousin, Male, 5 Year(s)	066536 - Father, Male, 30 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
066541 - Other Child - Cousin, Male, 3 Year(s)	066536 - Father, Male, 30 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
066541 - Other Child - Cousin, Male, 3 Year(s)	066536 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
066541 - Other Child - Cousin, Male, 3 Year(s)	066535 - Mother, Female, 29 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?	☒	☐	☐	☐

Additional information:

The SM and SF were interviewed. Important family collaterals were spoken with. OCDCDS attempted to speak with the CHN. The surviving cousins' parents were unable to be contacted or located although diligent efforts were made.

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:
OCDCFS offered the SM grief counseling resources for the family and burial assistance, and she declined stating she was receiving services through her tribal affiliation; however, by the end of the investigation she reported discontinuing counseling. The SM received assistance through a DV advocate and OCDCFS made efforts to improve the SMs engagement with the services. OCDCFS recommended the SF have a substance abuse evaluation, and he refused.

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?	☐	☒	☐	☐

Explain as necessary:
No children were removed from the parent's care.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	066535 Mother Female 29 Year(s)	
Comments:	A neglect petition was filed against the SM and SF but Onondaga County Family Court dismissed the petition stating they do not have jurisdiction due to the family's ICWA status.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	066536 Father Male 30 Year(s)	
Comments:	A neglect petition was filed against the SM and SF but Onondaga County Family Court dismissed the petition stating they do not have jurisdiction due to the family's ICWA status.	

Have any Orders of Protection been issued? No

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:
The SM initially reported she was attending counseling; however, near the end of the investigation stated she stopped attending. OCDCFS stressed the importance of the SM attending; however, she was uninterested. Funeral assistance was declined. The SM was already engaged with a DV advocate, although inconsistently. OCDCFS recommended the SF complete a substance abuse evaluation, and he refused.

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:
OCDCFS offered the SM grief counseling resources for the family, which she declined stating she was receiving services through her tribal affiliation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM declined burial assistance offered by OCDCFS. OCDCFS recommended to the SM several times that she remain engaged with counseling and DV services. They also recommended the SF attend a substance abuse evaluation, and he declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

- ☒ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☐ Was not noted in the case record to have any of the issues listed

Infant was born:

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

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)
08/23/2021	Sibling, Male, 1 Days	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:
OCDCFS received an SCR report alleging that on 8/22/21 the SM gave birth to the then 1-day-old SS. The SM was positive for marijuana. The baby tested negative for marijuana.

Report Determination: Unfounded **Date of Determination:** 09/21/2021

Basis for Determination:
OCDCFS unsubstantiated the allegations of Parent Drug and Alcohol Misuse against the SM regarding the then 1-day-old SS. The SS did not test positive for marijuana and there were no apparent negative impacts on him.

OCFS Review Results:
OCDCFS began the investigation within 24 hours and completed a CPS history review. The parents were interviewed at the hospital and the children were seen. The safety assessments were completed, but the 7-day assessment was 5 business days overdue. The RAP did not reflect relevant information regarding the family's history and incorrectly documented that the child was born with a positive toxicology. Safe Sleep was addressed. No home visit was completed. Preventive services were not offered. No collaterals were contacted, including the source, medical providers to confirm the SSs toxicology was negative, LE, or treatment providers. No plan of safe care was completed with the family.

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

Issue:
Failure to Offer Appropriate Services
Summary:
For the second time in less than a year, the SM had a positive toxicology when she gave birth to a child. The family had a history of DV and there were concerns for the SF's substance misuse. However, no preventive services were offered to the family.
Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
Based on the investigation and evaluation conducted, OCDCFS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Issue:
Failure to complete, document, and monitor a Plan of Safe Care
Summary:
OCDCFS failed to develop, document & monitor a Plan of Safe Care to address the health and substance use disorder treatment needs of both the infant and affected caregiver despite knowledge the infant was identified as being born exposed to substances.
Legal Reference:
17-OCFS-LCM-03 & 18-OCFS-LCM-06
Action:
OCDCFS will complete, document & monitor a Plan of Safe Care that specifically addresses the child(ren) affected by substance misuse and the affected caregiver. OCDCFS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The report alleged the SM was positive for marijuana at the time of the SSs birth and the SS tested negative. OCDCFS did not document confirming this information with the source and did not ask medical providers about the SSs health.

OCDCFS failed to request police records to determine if there had been any DV incidents since the last report, and failed to confirm if the OP was still in place.

Legal Reference:

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

Action:

OCDCFS 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.

[redacted]

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

From 10/12/20-12/11/20 an investigation was open regarding the SM having a positive toxicology at the time of the 1-day-old SSs birth. It was unsubstantiated for allegations of IG and PD/AM against the SM regarding the then 1-day-old SS. The SSs toxicology was negative for any substances, and she had no withdrawal symptoms.

From 7/20/20 through 10/16/20 an investigation was open with the SF. It was unsubstantiated against the SF for allegations of IG and PD/AM regarding his other three children.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: The SM had an OP put in place to protect her from the SF due to DV issues. It was unclear if the OP was still in place during the time of the fatality and most recent investigation.	

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