Child Fatality Report

Report Identification Number: SY-24-003

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

Issue Date: Jun 17, 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 **Jurisdiction:** Onondaga **Date of Death:** 01/11/2024
Age: 6 month(s) **Gender:** Male **Initial Date OCFS Notified:** 01/11/2024

Presenting Information

An SCR report was received on 1/11/24, alleging the SF administered cold medication to the 6-month-old SC, and then went to sleep with the SC in his bed. The SF woke up at an unknown time and observed he had rolled over onto the SC. The SC was unresponsive with cold blotchy skin. The SF immediately called 911. EMS arrived at the home at 3:00PM and began CPR. EMS continued to perform CPR while transporting the SC to the hospital. Upon the SC's arrival at the hospital, life-saving measures were continued but were unsuccessful. At 3:51PM, the SC passed away as the result of an unsafe sleep situation. On 1/12/24, a subsequent report was received alleging, the SM was aware of the SF's history of causing physical harm to children and he was not supposed to be unsupervised with the SC. Despite this, on 1/11/24, the SM left for work, leaving the SF and SC alone. During which time, the SC's heart stopped and he was transported to the hospital and pronounced deceased.

Executive Summary

Onondaga County Department of Children and Family Services (OCDCFS) received an SCR report on 1/11/24, regarding the death of the 6-month-old male subject child. The SCR report contained allegations of Inadequate Guardianship, Lack of Supervision, Lacerations/Bruises/Welts, and DOA/Fatality against the subject father regarding the subject child and an allegation of Inadequate Guardianship against the subject mother regarding the subject child. At the time of his death, the subject child resided with his mother, father, and paternal grandmother. The 5-year-old surviving sibling split time between the subject mother's residence and his father's respective residence, where his father and father's partner resided. The subject child had two other half-siblings, ages 6 and 2 years, that were placed in foster care and had supervised contact with the subject father and their mother.

OCDCFS requested that Oswego County Department of Social Services (OCDSS) take a primary role on the investigation due to OCDCFS having a conflict. Together, OCDCFS and OCDSS immediately assessed the safety of the surviving siblings. It was determined the 6 and 2-year-old surviving siblings were safe in foster care. A plan was made for the 5-year-old surviving sibling to remain in his father's care and for visits with the subject mother to be suspended.

OCDCFS learned on 1/11/24, the subject father administered cold medication to the subject child and then, around 10:00AM, laid down on his bed with the subject child in his arm to take a nap. The SF woke around 2:00PM and found the subject child in between his side and his arm. The subject child was unresponsive. The subject father called 911 and performed CPR. EMS arrived and continued CPR while transporting the subject child to the hospital. The subject child was pronounced deceased at 3:51PM.

OCDCFS was able to determine through interviews, a CPS history review and collateral contacts that the subject father's 6 and 2-year-old children were placed in foster care due to the 2-year-old surviving sibling sustaining 4 fractures throughout her body during her first month of life. On 11/3/22, the subject father made an admission in family court to abuse and neglect. The subject father was only allowed restricted, supervised contact with his children. The subject mother reported she was aware of the subject father's CPS history and that he was only allowed supervised contact with the 6 and 2-year-old surviving siblings; however, she continued to allow the subject father to be the sole caretaker of the subject child.

The final autopsy report was received on 3/21/24. The cause of death was sudden unexplained death in infancy (with extrinsic and intrinsic factors). The manner of death was undetermined. The intrinsic factor was the subject child being positive for Coronavirus OC43 infection and the extrinsic factor was bed sharing with his father in an adult bed. The

circumstance surrounding the subject child's death, stated the subject child was cradled in the subject father's right arm and the subject father woke to find the subject child with his face pressed against the subject father's armpit and flank area. After law enforcement received the final autopsy report, they closed their investigation.

OCDSS provided all the family members with grief counseling resources. It was unclear if these resources were utilized. The subject mother was already engaged in mental health counseling and after the subject child's death, she began meeting with the counselor several times a week. The subject father and paternal grandmother identified having their own mental health counselors. At the time this report was written, the case remained open and the allegations were pending.

PIP Requirement

OCFS' review resulted in citations. In response, each cited county will submit a Program Improvement Plan (PIP) to the Regional Office which will identify what action(s) the respective LDSS' have taken, or will take, to address the cited issues. For citations where a PIP is currently implemented, the respective LDSS will review the plan(s) and revise as needed to further 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?** — N/A
- **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?** — N/A

Explain:

At the time this report was written, the investigation remained open and had not been determined.

Was the decision to close the case appropriate? — N/A

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

Was there sufficient documentation of supervisory consultation? — Yes, the case record has detail of the consultation.

Explain:

Casework activity was not commensurate with case circumstance due to the 7-day and 30-day Safety Assessments not being completed, despite having a safety plan in place.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The 24-hour Safety Assessment documented an appropriate safety plan being made; however, at the time this report was written, OCDSS had not completed a 7-day or 30-day Safety Assessment.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/11/2024 **Time of Death:** 03:51 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: 03:00 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

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	Male	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Other Household 1	Father	No Role	Male	29 Year(s)

Other Household 1	Father's Partner	No Role	Female	26 Year(s)

LDSS Response

Upon receipt of the SCR report, OCDCFS initiated their investigation within 24 hours, coordinated their efforts with LE and contacted OCDSS to assist in the investigation. The sources were contacted, CPS history was reviewed, the DA was notified, and OCDCFS communicated with the ME. The 6 and 2yo SSs were assessed to be safe in foster care. A plan was made for the 5yo SS to remain in the care of his father and visitation with his mother was suspended.

OCDCFS and LE met with the parents on 1/11/24. On that same date, the SF reported he was home with the SC. The SF explained the SC was sick for a few days with a cough and congestion and was unsure if the SC had a fever. Around 10 or 11:00AM, the SF administered medication to the SC and then they both went to sleep. When the SF fell asleep, he was holding the SC in his arm to the side of himself. When he woke, around 2:00PM, the SC had slid down and was between the SF's arm and the side of his body. The SF stated the SC's face was pressed into the side of the SF's body. The SF picked the SC up and he was limp. The SF placed the SC back down and started pushing on his chest and blowing in his mouth. The SF called 911. The SF reported the SC was acting normal all day besides some congestion and coughing. The SF reported the SC usually slept in his Pack N' Play but the Pack N' Play was not at the home because the SC was going to spend the night at his PA's home. The family gave the PA the Pack N' Play the day before the incident. The home was observed to have two bedrooms. The parent's room had a bed that took up most of the room. There did not appear to be room for a Pack N' Play. The second bedroom was the PGM's. While speaking with the parents a pillow was moved on the bed exposing an unrolled joint, which the father stated was marijuana. He then proceeded to roll a joint and stick it behind his ear. An ashtray was observed to have empty blunt packages and tobacco. The SF denied any drug use except for marijuana; however, OCDCFS did not inquire if the SF was under the influence at the time of the fatal incident. The SM and PGM both reported they were at work during the incident. The SM reported the day of the incident the SC had a cold and was developing a cough, due to this, instead of sending him to the babysitters she left him home with the SF. The SM explained, that over the weekend she had reached out to the SC's pediatrician because he had a fever. The SM reported the SC's Pack N' Play had been with the PA because she was going to take him for the night. The PGM had nothing to add regarding the fatal incident.

Records were received from first responders. They responded to a call that the SC was in cardiac arrest. Upon arrival, the SF was found screaming in the apartment with the SC in his hands. The SC was seen as limp and unresponsive. The SF stated he thought he rolled on the SC while he was sleeping. The SC had no obvious signs of trauma. He did have a small bruise on the top of his head, it appeared to be an older bruise that was black and blue. EMS attempted life-saving measures without success. The SC was brought by ambulance to the hospital. Records were received from the hospital that indicated the SC presented at the hospital in cardiac arrest. The record stated that per EMS and LE the SC was co-sleeping with the SF and the SF woke up partially covering the SC.

OCDSS collected records from the hospital, the ME, first responders, the SC's pediatrician, the 5yo SS's pediatrician, and the SM's health care provider. OCDSS had consistent communication with the family members, collaterals, and LE throughout the case. Progress notes were entered timely, notifications were provided and resources for grief counseling were given. The 7-day Safety Assessment was due to be completed by 1/18/24 and the 30-day Safety Assessment was due to be completed by 2/10/24. At the time this report was written neither safety assessment had been completed and both were overdue.

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

Comments: Oswego County Department of Social Services took primary on the investigation. OCDSS has a local OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
067128 - Deceased Child, Male, 6 Month(s)	067129 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Pending
067128 - Deceased Child, Male, 6 Month(s)	067130 - Father, Male, 24 Year(s)	Inadequate Guardianship	Pending
067128 - Deceased Child, Male, 6 Month(s)	067130 - Father, Male, 24 Year(s)	DOA / Fatality	Pending
067128 - Deceased Child, Male, 6 Month(s)	067130 - Father, Male, 24 Year(s)	Lacerations / Bruises / Welts	Pending
067128 - Deceased Child, Male, 6 Month(s)	067130 - Father, Male, 24 Year(s)	Lack of Supervision	Pending

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?	☐	☒	☐	☐

Explain as necessary:
The 2 and 6yo SSs were already in foster care at the time of the fatality.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Have any Orders of Protection been issued? No

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☒	☐	☐	☐	☐	☐
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
All family members were offered bereavement services. The SM, SF and PGM all reported being engaged with their own mental health providers.

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
OCDSS provided the family with bereavement counseling resources.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
OCDSS provided the family with bereavement counseling resources.

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? Yes

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

- [ ] With a positive toxicology
- [ ] With fetal alcohol effects or syndrome
- [ ] Exhibiting withdrawal symptoms
- [x] 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)
01/11/2024	Deceased Child, Male, 6 Months	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 2 Years	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6 Years	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 2 Years	Father, Male, 24 Years	Fractures	Substantiated	
	Sibling, Female, 2 Years	Other Adult - SS's BM, Female, 23 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6 Years	Other Adult - SS's BM, Female, 23 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 2 Years	Other Adult - SS's BM, Female, 23 Years	Fractures	Substantiated	
	Deceased Child, Male, 6	Mother, Female, 24 Years	Inadequate	Substantiated	

Months		Guardianship		
Sibling, Male, 5 Years	Father, Male, 24 Years	Fractures	Unsubstantiated	
Sibling, Male, 5 Years	Father, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received on 1/11/24, alleging the SF physically assaulted the 5yo SS for an unknown reason. As a result, the 5yo SS sustained broken bones.

Report Determination: Indicated | **Date of Determination:** 04/02/2024

Basis for Determination:
The allegations regarding the injuries against the 5yo SS were pertaining to a previous investigation from 11/23/21, involving the then 2yo SS. When the then 2yo SS was less than a month old she was discovered to have 4 fractures throughout her body. The parents had no explanation for the injuries and as a result, a neglect petition was filed against them in family court. On 2/12/23, the then 3yo and 28-day-old SSs were placed into foster care. On 11/3/22, the parents made admissions in family court. The SM was aware of the SF's CPS history and the injuries the then 2yo SS sustained when she was 28-day-old, and still allowed the SF to be a caretaker for the SC.

OCFS Review Results:
OCDCFS focused their investigation on the fatality and not the allegations pertaining to this SCR report. The case lacked sufficient information pertaining to the exact allegations; although, the indicated allegations were justified in the investigation determination based on CPS history. OCDCFS spoke with the source, completed a CPS history review, interviewed the family members, except for the PGM, and had contact with LE, medical providers, and a school. The wrong caregiver was selected in the RAP and not all the risk elements were documented. The Safety Assessments were completed timely and accurately. The case was closed with a plan for OCDSS to continue investigating the fatality.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The investigation lacked focus on the initial allegations and focused on the subsequent report regarding the fatality. OCDCFS justified their decision in the determination; however, there was a lack of supporting evidence throughout the investigation. OCDCFS did not attempt to speak with the PGM and added the wrong caretaker to the RAP changing the risk rating.

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

Action:
OCDCFS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/28/2023	Sibling, Male, 4 Years	Father, Male, 23 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 1 Months	Father, Male, 23 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Years	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 1	Mother, Female, 24	Inadequate	Substantiated	

	Months	Years	Guardianship		

Report Summary:
An SCR report was received on 7/28/23, alleging the SF had a child removed from his care due to physical abuse and that child had not been returned to his care. The SF had a newborn child with the SM. It was unknown if the SM was aware that the SF was violent towards the other child.

Report Determination: Indicated | **Date of Determination:** 09/26/2023

Basis for Determination:
OCDCFS substantiated the allegations of IG against the SM and SF regarding the SC and the 5yo SS. The SM admitted on multiple occasions she was aware of the injuries the SF caused to his older child and continued to allow him to be a caregiver for her CHN. The SM was compliant but continued to question why the SF could not be in the home and why he was an inappropriate caregiver. Despite his CPS history and pending criminal charges, the SF did not understand why he was not an appropriate caregiver. The 5yo SS disclosed the SF being at the home after CPS involvement, that the SF and SM would argue causing the SC to cry, and that the SF hit the SM in his presence while the SM was pregnant.

OCFS Review Results:
OCDCFS began their investigation within 24 hours and made a safety plan with the SM; however, the safety plan was not appropriately documented in the safety assessments. The initial safety assessment was completed late. OCDCFS attempted to engage the SF, but he was confrontational. OCDCFS made diligent home visits throughout the investigation to determine if the safety plan was being followed. The SM denied DV; however, OCDCFS did not confront the SM or SF when the 5yo SS disclosed he witnessed the SF hit the SM. OCDCFS thoroughly went over safe sleep with the SM. OCDCFS did not offer the SM preventive services despite the same concerns being present at the end of the investigation.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
During their investigation OCDCFS learned there were concerns the SF was selling drugs and ongoing concerns for DV. OCDCFS did not address the concerns regarding the SF selling drugs. The SM denied DV; however, on multiple occasions new information regarding the DV concerns were brought to OCDCFS's attention and they did not follow up with the SM.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. OCDCFS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
OCDCFS made a safety plan with the SM that the SF would not be around the CHN. The SM agreed and the plan remained in place throughout the investigation. The safety plan was not documented in either safety assessment.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:
The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Issue:
Failure to Offer Appropriate Services

Summary:
Throughout the investigation the SM was compliant but struggling to understand the importance of following the safety plan. The safety plan was still in place at the close of the investigation. Continuously, throughout the investigation, concerns for DV came to OCDCFS's attention. Despite these concerns preventive services were not offered to the SM.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/23/2021	Sibling, Female, 1 Days	Other Adult - SS's BM , Female, 20 Years	Fractures	Substantiated	No
	Sibling, Female, 1 Days	Other Adult - SS's BM , Female, 20 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 1 Days	Father, Male, 22 Years	Fractures	Substantiated	
	Sibling, Female, 3 Years	Father, Male, 22 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 3 Years	Other Adult - SS's BM , Female, 20 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report was received on 11/23/21, alleging the then 1-day-old SS was positive for marijuana at birth. Additional information was received, on 12/20/21, alleging the SF transported the then 28-day-old SS to the hospital because the SS was irritable. An abrasion was noticed around the SS's mouth and there was a small burn to her upper mouth palate caused from the SS's bottle being too hot. A full skeletal exam was performed. An internal mark was found on the bone in the SS's leg. A follow-up visit was scheduled to have the SS's leg rescanned. If the mark was persistent or became worse, it would have been considered suspicious.

Report Determination: Indicated | **Date of Determination:** 02/10/2022

Basis for Determination:
OCDCFS substantiated the allegations of FX regarding the then 28-day-old SS against her BM and the SF and substantiated the allegations of IG regarding the then 28-day-old and 3yo SSs against their BM and the SF. OCDCFS unsubstantiated the allegations of PD/AM regarding the then 28-day-old SS against her BM. The 28-day-old SS had a follow up scan on 1/7/21, that revealed 4 fractures. The parents had no explanation for the 28-day-old SS's injuries. The SSs were placed with their MGM and a petition was filed against the parents.

OCFS Review Results:
OCDCFS began their investigation within 24 hours, spoke with the source, and completed a CPS history review. The family was interviewed, and all significant collaterals were contacted. OCDCFS made a safety plan with the parent's due to the 28-day-old SS's severe injuries that were unexplained. OCDCFS filed a petition in family court against the parents and the 28-day-old and 3yo SSs were removed from the parent's care and placed with their MGM. OCDCFS completed both safety assessments and the risk assessment accurately and documented the progress notes timely. The investigation was closed and opened into a preventive services case.

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

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

An investigation was opened from 7/13/18-10/23/18. Allegations of IG against the SF were substantiated regarding the then 6-month-old surviving sibling due to the SF burglarizing a residence and returning to the scene of the crime with the 6-month-old SS and then leaving her in the car with a backpack containing marijuana.

Preventive Services History

A preventive service case was opened on 1/19/22, regarding the SF, the then 3yo and 1-day-old half-siblings and their mother. The case was initially opened when OCDCFS filed a family court petition against the SF and the then 3yo and 1-day-old SS's mother due to the 1-day-old SS having severe injuries that the parents were unable to explain. The SF brought the 1-day-old SS to be seen by a medical professional, who determined there was a burn on her lip and abnormalities in an x-ray. A more thorough exam was performed, at which time it was determined the then 1-day-old SS had 4 fractures throughout her body. A safety plan was made, and the children went to reside with their MGM. The parents were only allowed supervised contact with the SSs.

Foster Care Placement History

The safety plan made on 1/14/22 became a formal removal on 2/12/23, and the then 30yo and 1-day-old SSs remained in the MGM's kinship home. On 2/12/23, they were placed as foster children. The preventive case remains open, and the children remain in foster care.

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
01/14/2022	Adjudicated Abused	Order of Supervision
Respondent:	067130 Father Male 24 Year(s)	
Comments:	The SF was found to have abused and neglected the SSs and was placed under the supervision of OCDCFS.	

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Father	Unknown	Unknown
Comments:	The SF was charged with Endangering the Welfare of Child regarding the then 1-day-old SS that sustained fractures.		

Criminal Charge: Assault **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**

Unknown	Father	Unknown	Unknown
Comments:	The SF was charged with assault regarding the then 1-day-old SS sustaining fractures.		

Have any Orders of Protection been issued? Yes	
From: 12/01/2023	**To:** 12/01/2024
Explain: A full stay away OP was issued against the SF regarding the then 5yo and 2yo SSs.	
From: 08/02/2022	**To:** Unknown
Explain: An OP was issued against the SF regarding the then 1-day-old SS.	

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