Child Fatality Report

Report Identification Number: SY-22-004

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

Issue Date: Jul 12, 2022

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 has an open 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		
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	
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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 01/25/2022
Initial Date OCFS Notified: 01/25/2022

Presenting Information

Two SCR reports were received that alleged the mother left the 2-month-old infant in the care of an inappropriate babysitter on 1/24/22. The mother was aware that the babysitter was not an appropriate caregiver due to the babysitter's history of her own children being removed from her care, a history of drug misuse and mental health issues. On the morning of 1/25/22, the babysitter found the infant unresponsive with no pulse and a body temperature of 89 degrees. The infant was found in a car seat on top of a bed. The babysitter was under the influence of molly and synthetic marijuana when the infant was found unresponsive. There was drug paraphernalia found in the home. The babysitter's timeline of events was not consistent, based on the infant's body temperature at the time EMS arrived. The infant was pronounced deceased at the hospital at 11:01 AM.

Executive Summary

On 1/25/22, the Onondaga County Department of Social Services (OCDSS) received two SCR reports regarding the death of the 2-month-old male infant that occurred on that date. OCDSS had an open CPS investigation at the time, with concerns that the infant was born premature at 30 weeks gestation and the mother and infant tested positive for marijuana at the time of his birth. The mother had two other children, aged 10 and 8, who were in the custody of the maternal grandmother since 2014 due to a finding of Neglect against the mother and the 10-year-old sibling's father. The mother and the infant's father were separated, and the father had only seen the infant twice since he was discharged home from the Neonatal Intensive Care Unit (NICU) to the mother on 12/27/21. The infant's father had two additional children, aged 17 and 14, who resided with their mothers. The father visited the children often, but they had not yet met the infant.

Through a joint investigation with law enforcement, OCDSS learned that on 1/7/22, the visiting nurse that worked with the mother and infant became concerned that the infant was losing weight and that the mother needed assistance caring for the infant. The nurse planned with the family for the infant to stay with the maternal grandmother for a period. While in the grandmother's care, the infant thrived, and he gained weight. The infant returned to the mother's care on 1/20/22.

On 1/24/22, the mother dropped the infant off at the babysitter's home for the night. The infant slept in his car seat on top of an adult bed. The babysitter's cousin came to the home around 8:00 AM on 1/25/22, and he fell asleep in the adult bed next to the infant's car seat. The babysitter said she fed the infant a bottle around 9:00 AM, then she placed him back in his car seat. She said she then went outside and used synthetic marijuana. At 9:50 AM, she returned inside, and she checked on the infant. The infant was still in the same position in the car seat, and he was unresponsive. The babysitter called 911 and she performed CPR. When EMS arrived, the infant had no pulse, and his body temperature was 89 degrees. The infant was transported to the hospital via ambulance, where life saving measures continued. The infant was pronounced deceased at 11:01 AM.

An autopsy was performed, and the cause of death was unexplained sudden death of infant with the intrinsic and extrinsic factors of normally developed premature infant, placed in an unsafe sleep environment, positive for bronchopneumonia, cardiac genetic testing positive for variant of uncertain significance, and dilated colon and rectum. The manner of death was undetermined. The infant was found to have no trauma or injuries. The law enforcement investigation remained open at the time this report was written.

OCDSS referred the family for bereavement services and funeral assistance. The investigation had not yet been determined at the time of this writing. OCDSS determined the babysitter was not a regular and consistent caretaker for the

infant; therefore, she was not a person legally responsible for the infant's care. The investigation revealed that the mother was aware the babysitter had a history of drug misuse, mental health concerns and failing to adequately care for her own children. The mother had no children in her custody at the time of this writing; however, she disclosed that she was expecting another child. OCDSS planned to offer the mother services related to the ongoing concerns for her mental health and drug misuse and to consult their legal department to formulate a plan for protecting the unborn child when the mother gives birth.

PIP Requirement

OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS 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?** 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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:

The case had not yet been determined at the time of this writing.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:

OCDSS continued to investigate the circumstances surrounding the infant's death.

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: 01/25/2022 **Time of Death:** 11:01 AM

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: 09:57 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☒ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes

At time of incident was supervisor impaired?
☒ Drug Impaired ☐ Alcohol Impaired
☐ Impaired by illness ☐ Impaired by disability
At time of incident supervisor was:
☒ Distracted ☐ Absent
☐ Asleep ☐ 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	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Other Household 1	Father	No Role	Male	37 Year(s)
Other Household 2	Other - Babysitter	No Role	Female	38 Year(s)

LDSS Response

OCDSS contacted the sources of the reports, reviewed SCR history, and notified the DA's office of the death. They

received and reviewed the 911 call and records from the hospital, EMS, and the agency that provided visiting nursing services to the family. OCDSS assessed the safety of the homes of the mother, father, maternal grandmother, and babysitter. The parents, babysitter, and siblings were interviewed, and the siblings were assessed to be safe.

The mother reported that she dropped the infant off at the babysitter's home around 7:00 PM on 1/24/22. She said the babysitter was a friend of hers and it was the first time she cared for the infant. She met the babysitter outside and the babysitter did not appear to be impaired. She said the babysitter used to use synthetic marijuana and molly, but she did not think the babysitter still used them. When she woke up the next morning, she had a text from the babysitter telling her that the infant was at the hospital, so she immediately went there. The mother said the babysitter later told her that she did not go to the hospital with the infant because she was "too high". The mother said she was aware the babysitter did not have custody of her own children, but she did not know why.

The babysitter reported that she was friends with the mother, and this was the first time she cared for the infant. She said she cared for the infant on 1/24/22 so the mother could get some rest. Her timeline of events contradicted what the mother reported. She said the mother dropped the infant off at her house around 8:00 AM, and she had used molly just prior to the mother dropping him off. She said the mother returned to her home around 10:00 AM, and she checked on the infant. The babysitter fed the infant 4 ounces of a bottle at that time and then he went to sleep in his car seat. Her friend fed the infant a second bottle later in the day and her friend said the infant was congested, and she had to suction his nose. The babysitter said the infant was sleeping when she went to bed around 7:00 PM, and he slept all night in his car seat on an adult bed. She woke up between 7:30-8:00 AM when her cousin arrived. The infant was still sleeping so she changed his diaper and placed him back in the car seat. Around 9:00 AM, she fed the infant a bottle and she placed him back in his car seat. She then went outside and used synthetic marijuana. When she returned inside at 9:50 AM, she discovered the infant was unresponsive.

The father said he told hospital staff and OCDSS when the infant was born that they should not discharge the infant to the mother because she was using drugs and she had mental health issues. He denied having met the babysitter, but he said he was aware she had a history of drug use.

Hospital staff said the father had to be escorted outside because he became physical with the mother, and he was yelling at her for leaving the infant with someone she knew used drugs. Hospital staff said EMTs reported that when they arrived, there were drugs and drug paraphernalia found in the home and the babysitter was under the influence of molly and synthetic marijuana. Staff further reported that the babysitter's timeline of feeding the infant around 9:00 AM was not consistent with the infant's temperature at the time EMS arrived.

Law enforcement reported the babysitter had moved the infant to the living room floor, and she was performing CPR when they arrived. The car seat was still on the bed, and it was positioned between the wall and the babysitter's cousin. The babysitter's cousin had yet to be interviewed by OCDSS, but he reported to law enforcement that the infant's hands were cold when he arrived at the home that morning. The infant's medical records documented that he was born premature, his weight was being closely monitored, and he was seen for bowel issues and a possible hernia. The CPS investigation remained open at the time this report was written.

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: The case was referred to the Onondaga County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060630 - Deceased Child, Male, 2 Mons	060631 - Mother, Female, 34 Year(s)	DOA / Fatality	Pending
060630 - Deceased Child, Male, 2 Mons	060631 - Mother, Female, 34 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

Additional information:
Attempts to interview the babysitter's cousin were not documented. The babysitter's cousin was sleeping in the same bed as the infant at the time the infant was found unresponsive.

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?	☐	☐	☒	☐
Explain: The 30-Day Safety Assessment was due 2/24/22 and it was completed and approved on 3/1/22.				

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: Service needs surrounding the mother's untreated substance use and mental health concerns had not been adequately explored. The mother was court-ordered to engage in substance abuse, mental health, and anger management services in 2014 and she did not engage in these services. A review of the case revealed that OCDSS had yet to refer the mother for these services or to explore any additional service needs the mother may have since she is pregnant. OCDSS agreed to explore the mother's service needs and to refer her for the necessary services.				

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The 10 and 8-year-old siblings remained in the custody of the maternal grandmother.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☒	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☒	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☒	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
There were no service needs identified for the siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother and father were provided with information on bereavement services and funeral assistance. It was not documented if they utilized these services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? Yes
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:
☒ Drug exposed
☐ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

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)
11/02/2021	Deceased Child, Male, 1 Days	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 1 Days	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged the mother gave birth to the infant on 11/1/21. The mother and infant's toxicology were positive for marijuana at the time of delivery.

Report Determination: Unfounded | **Date of Determination:** 01/31/2022

Basis for Determination:
The infant was born at 30 weeks gestation with a positive toxicology for marijuana. The mother admitted to using marijuana during pregnancy and she denied drug use since giving birth. There was a lack of credible evidence that the

mother's marijuana use had a negative effect on the infant or that it caused the premature birth. The mother did not visit the infant regularly in the NICU and the father voiced concerns when the infant was discharged on 12/27/21, that the mother was using molly. The mother was drug tested on that date for cocaine only and it was negative. The infant received visiting nursing services to monitor his weight.

OCFS Review Results:
A Plan of Safe Care was not completed as required. OCDSS discussed with the mother that she had not completed court-ordered services from 2014, and that the siblings remained in the grandmother's custody. OCDSS did not refer the mother for these services or consult with their legal department about filing for court intervention. On 1/7/22, the visiting nurse made a safety plan for the infant to stay with the grandmother for a period since he lost weight. The infant gained weight and he thrived in the grandmother's care. The infant returned to the mother's care on 1/20/22, without OCDSS being consulted. OCDSS did a home visit on 1/21/22, and they observed the infant to appear healthy.

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

Issue:
Failure to complete, document, and monitor a Plan of Safe Care

Summary:
The mother and infant had a positive toxicology for marijuana at the time of the infant's. OCDSS did not complete, document and monitor a Plan of Safe Care as required.

Legal Reference:
17-OCFS-LCM-03 & 18-OCFS-LCM-06

Action:
OCDSS will complete, document & monitor a Plan of Safe Care that specifically addresses the child(ren) affected by substance misuse and the affected caregiver. OCDSS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

Issue:
Assessment as to need for Family Court Action

Summary:
The mother had a history of drug misuse and a finding of Neglect in 2014 regarding the siblings. The mother did not complete court-ordered services, resulting in the siblings remaining in the custody of the grandmother. OCDSS did not consult with their legal department about filing for Family Court intervention for the protection of the infant.

Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:
OCDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

[redacted]

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

An SCR report dated 6/28/11 with allegations of Parent's Drug/Alcohol Misuse against the mother was tracked FAR. The oldest sibling tested positive for marijuana at birth.

An SCR report dated 8/26/13 was unsubstantiated for the allegations of Inadequate Guardianship and Lack of Supervision against the mother regarding the oldest sibling.

An SCR report dated 12/11/13 with allegations of Inadequate Guardianship and Parent's Drug/Alcohol Misuse against the mother regarding the youngest sibling was tracked FAR. The mother and youngest sibling tested positive for marijuana at birth.

An SCR report dated 3/5/14 with allegations of Inadequate Guardianship regarding the two siblings and Lack of Medical Care regarding the oldest sibling against the mother was tracked FAR.

An SCR report dated 8/28/14 was substantiated for the allegations of Burns/Scalding, Inadequate Food/Clothing/Shelter, Inadequate Guardianship, and Lack of Medical Care against the mother and oldest sibling's father as well as Parent's Drug/Alcohol Misuse against the mother regarding the siblings. The siblings were removed and placed in Foster Care.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

Preventive Services History

An ongoing CPS Services Case opened on 9/2/14 regarding the mother, oldest sibling's father and the siblings. The mother was impaired on drugs, was in possession of drugs, and she was displaying erratic behavior. The siblings were dirty and unkempt, the youngest sibling was sick and in need of medical attention, and the oldest sibling was in need of emergency dental care. The father of the oldest sibling was arrested on an outstanding warrant and the mother was arrested and transported for emergency mental health treatment. The siblings were removed and placed in Foster Care. On 9/12/14, the siblings were placed with the maternal grandmother under Article 1017 and the siblings were adjudicated Neglected. The mother failed to complete a substance abuse evaluation, psychological evaluation or anger management program. She did not obtain and maintain safe and stable housing for the siblings or visit the siblings consistently. The oldest sibling's father failed to complete a substance abuse evaluation or parenting class. He did not obtain and maintain safe and stable housing, or visit consistently with the oldest sibling. The grandparents obtained Article 6 custody of the siblings on 1/9/15, and the case closed on 4/5/16.

Foster Care Placement History

The siblings were placed in Foster Care on 8/28/14 due to the mother being impaired by drugs and displaying erratic behavior, the oldest sibling's father being arrested on an outstanding warrant, and the siblings needing medical treatment. The siblings were subsequently placed with the maternal grandmother on 9/12/14 under Article 1017 and the siblings were adjudicated Neglected.

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