Child Fatality Report

Report Identification Number: SY-22-006

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

Issue Date: Aug 02, 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: 13 year(s)
Jurisdiction: Madison
Gender: Female
Date of Death: 02/06/2022
Initial Date OCFS Notified: 02/06/2022

Presenting Information

An SCR report alleged on 2/5/22, the mother left the 13-year-old subject child and 14-year-old sibling home alone overnight. The mother often left the children home alone overnight while she worked. The mother's partner was aware the children were left home alone and he failed to provide any supervision for the children. The mother's partner dropped the mother off at work at 9:00 PM, then he dropped off food to the children at 10:30 PM. The mother and her partner did not return to the home until 11:45 AM on 2/6/22. The mother and her partner went upstairs upon returning home and found the subject child on her bed, laying on her back. The child was unresponsive and cold to the touch. The mother and her partner immediately called 911. The child was pronounced deceased at 12:10 PM. The mother and her partner had no explanation for the child's death. The child sustained a sprained neck while sledding on 2/5/22, and the mother failed to seek medical treatment for the child.

Executive Summary

On 2/6/22, the Madison County Department of Social Services (MCDSS) received an SCR report regarding the death of the 13-year-old female subject child. At the time of the child's death, she resided with her mother and three siblings, ages 14, 6, and 3. The mother and her partner, who frequented the home, were alleged subjects. The mother had custody of the subject child and siblings, and their father had visitation. The father moved out of the country in 2020, and he had not seen the children since that time. MCDSS spoke to the father on the phone, and he reported having no concerns for the children in the mother's care. The mother's partner had two additional children, ages 16 and 5, who were assessed to be safe in the custody of their mothers.

Through a joint investigation with law enforcement, it was learned that on 2/5/22, the subject child and 14-year-old sibling were home all night while the mother worked, and the two youngest siblings were at the maternal aunt's house. The mother's partner dropped off food to the children around 10:15 PM, and both children appeared fine at that time. The mother and her partner returned to the home around 11:00 AM on 2/6/22, and the child was in the mother's bedroom. When the mother checked on the child around 11:50 AM, she discovered that the child was in the mother's bed, and she was cold and unresponsive. The mother called 911 and EMS responded. First responders determined the child was deceased, so life-saving measures were not performed. The child was pronounced deceased at the home at 12:10 PM.

An autopsy examination found no evidence of trauma to the child's body. On 4/21/22, toxicology results showed the child had 5.7 ng/ML of fentanyl in her blood. The cause of death was determined to be toxic effects of fentanyl and the manner of death was accidental. During the investigation of the scene, law enforcement found empty packages for synthetic marijuana and a grinder in the night stand next to the mother's bed. The law enforcement investigation remained open, and charges had not been filed at the time this report was written.

MCDSS substantiated the allegations of DOA/Fatality, Inadequate Guardianship, Lack of Supervision and Child's Drug/Alcohol Misuse against the mother and her partner regarding the subject child, Inadequate Guardianship and Lack of Supervision against the mother and her partner regarding the 14-year-old sibling, and Educational Neglect against the mother regarding the 14-year-old sibling. The mother was previously advised not to leave the 14-year-old sibling unsupervised with any children following an incident in October 2021. Despite this knowledge, the mother left the subject child unsupervised with the sibling overnight. The mother and her partner denied any knowledge of the child's drug use. They did not fully cooperate with the criminal investigation into how the child obtained fentanyl and they were both aware there was drug paraphernalia in the mother's nightstand that was accessible to the child. The 14-year-old sibling was

absent for over 110 days of the 2020-2021 school year, and he only attended 5 days in the 2021-2022 school year. The allegation of Lack of Medical Care was unsubstantiated against the mother regarding the subject child. Although it was alleged the child hurt her neck while sledding earlier in the day on 2/5/22, there was no evidence the injury required medical attention or that it contributed to the child's death.

Following the child's death, the 14-year-old sibling went to live with the maternal grandmother and the mother and two youngest siblings moved to Onondaga County as well. Onondaga County Department of Social Services (OCDSS) assessed the mother's and grandmother's homes to be safe. Based on concerns for his criminal history, the mother was advised not to leave the children alone in the care of her partner. MCDSS provided the mother with information on bereavement services and the case closed on 5/17/22.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The case was appropriately indicated based on evidence gathered.

Was the decision to close the case appropriate? Yes

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

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

Explain:
There were supervisory consultations documented throughout the case and all investigative requirements were completed. The decision to close the case in Madison County was appropriate since the family moved to Onondaga County.

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: 02/06/2022 **Time of Death:** 12:10 PM

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

County where fatality incident occurred: Madison
Was 911 or local emergency number called? Yes
Time of Call: 12:02 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
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? No - but needed

At time of incident was supervisor impaired? Not impaired.
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	Female	13 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	14 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Other Household 1	Father	No Role	Male	33 Year(s)
Other Household 2	Mother's Partner	Alleged Perpetrator	Male	32 Year(s)

LDSS Response

MCDSS investigated the child's death by reviewing SCR history and speaking to the source of the report, law enforcement, the pediatrician, the medical examiner, school staff, the PINS Diversion caseworker, and the placement diversion counselor.

The mother, her partner, and the 14-year-old sibling provided consistent accounts of the incident. They said the mother and children went sledding in the afternoon and the child said her neck hurt so they went home. The mother then went to work, leaving the two oldest children home unsupervised and she brought the two youngest siblings to the maternal aunt's home. The mother asked her partner to drop food off to the children. He dropped off food around 10:15 PM, and he left the home by 10:30 PM. He said both children appeared to be fine at that time. Around 1:00 AM, the mother texted the child and asked if she was still awake and she replied that she was. Around the same time, the 14-year-old sibling went upstairs to the mother's bedroom and asked the child for a game controller, to which she said no. The sibling went back to the bedroom around 3:00 AM, and he observed the child to be sleeping in the mother's bed. He took the game controller and went back downstairs. The sibling said he was awake all night and he did not have any knowledge of the child using drugs. The mother's partner picked her up from work at 9:00 AM, and they arrived at the home around 11:00 AM. They assumed the child was still sleeping so they did not check on her until around 11:50 AM. When the mother checked on the child, she saw that the child was lying on her back on the mother's bed, and she had one arm underneath her body in an awkward position. The mother and her partner called 911 when they realized the child was cold and unresponsive. The sibling said he was asleep at that time, and he woke up when the mother screamed.

The mother and her partner denied having any suspicion that the child was using drugs or knowledge of where she obtained fentanyl. They reported that the empty synthetic marijuana packets found in the nightstand belonged to a maternal aunt who used to reside in the home, but they declined to do a polygraph test. The maternal aunt was interviewed by law enforcement, and she denied that she used synthetic marijuana or that she left packages of the drug in the home.

Law enforcement reported that the child was found lying on her back and unresponsive on the mother's bed around 11:50 AM. She was wearing pajamas and there were no visible signs of injury or trauma. The officer said the brand of synthetic marijuana found in the mother's nightstand was known to have fentanyl mixed into the substance. At the time of this writing, law enforcement had not determined where the child obtained fentanyl.

Pediatrician records showed that the children were healthy, and the subject child and oldest sibling denied using drugs or alcohol at their last appointment. It was documented that an incident occurred between the 14-year-old sibling and the 3-year-old sibling on 10/20/21, and the mother agreed not to leave the 14-year-old sibling unsupervised with the other children. School staff had no concerns for the subject child, but they had concerns for the 14-year-old sibling's attendance and failing grades. The placement diversion counselor and the PINS diversion caseworker reported that the mother had not followed through with recommendations and the 14-year-old sibling continued to miss school.

MCDSS consulted with their legal department throughout the investigation and they were advised against filing a Neglect Petition. MCDSS coordinated investigative efforts with OCDSS and OCDSS reported they found no concerns warranting the filing of a Neglect Petition. MCDSS provided the mother with contact information for a community resource in Onondaga County to obtain services for the 14-year-old sibling.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059625 - Deceased Child, Female, 13 Year(s)	060701 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
059625 - Deceased Child, Female, 13 Year(s)	060701 - Mother, Female, 32 Year(s)	Childs Drug / Alcohol Use	Substantiated
059625 - Deceased Child, Female, 13 Year(s)	060701 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
059625 - Deceased Child, Female, 13 Year(s)	060701 - Mother, Female, 32 Year(s)	Lack of Supervision	Substantiated
059625 - Deceased Child, Female, 13 Year(s)	060706 - Mother's Partner, Male, 32 Year(s)	DOA / Fatality	Substantiated
059625 - Deceased Child, Female, 13 Year(s)	060706 - Mother's Partner, Male, 32 Year(s)	Childs Drug / Alcohol Use	Substantiated
059625 - Deceased Child, Female, 13 Year(s)	060706 - Mother's Partner, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
059625 - Deceased Child, Female, 13 Year(s)	060706 - Mother's Partner, Male, 32 Year(s)	Lack of Supervision	Substantiated
059625 - Deceased Child, Female, 13 Year(s)	060701 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
060702 - Sibling, Male, 14 Year(s)	060701 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
060702 - Sibling, Male, 14 Year(s)	060701 - Mother, Female, 32 Year(s)	Lack of Supervision	Substantiated
060702 - Sibling, Male, 14 Year(s)	060706 - Mother's Partner, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
060702 - Sibling, Male, 14 Year(s)	060706 - Mother's Partner, Male, 32 Year(s)	Lack of Supervision	Substantiated
060702 - Sibling, Male, 14 Year(s)	060701 - Mother, Female, 32 Year(s)	Educational Neglect	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 father resided in another country so he was unable to be interviewed face to face, but he was interviewed over the phone.

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:
Service needs related to the educational neglect were not fully explored. The family would have benefited from a referral for preventive services in Onondaga County.
Services related to the fatality were offered.

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☒	☐	☐	☐	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☒	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐

Alcohol/Substance abuse	☐	☐	☐	☒	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☒	☐	☐	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The mother was provided with information on bereavement services 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 was provided with information on bereavement services. It was unknown if she utilized this service.

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? No
Was the child acutely ill during the two weeks before death? No

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)
11/09/2021	Sibling, Male, 14 Years	Mother, Female, 32 Years	Educational Neglect	Unsubstantiated	No
	Sibling, Male, 14 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the now 14-year-old sibling was absent from school 33 days during the 2021-2022 school year thus far and he was failing as a result. The mother was aware of the concern and she failed to address the situation.

Report Determination: Unfounded
Date of Determination: 12/07/2021

Basis for Determination:
There was a lack of credible evidence to support the allegations. The mother and children were residing with the maternal grandmother, maternal aunt and infant cousin. The adults reported they tried to make the now 14-year-old sibling go to school but he refused to go. The mother had contacted the PINS diversion program prior to receipt of the SCR report. A placement diversion referral was made and the mother began the intake process during the investigation.

OCFS Review Results:
MCDSS assessed the home for safety. They interviewed the mother, grandmother, aunt, subject child, and siblings, and they observed the cousin. Attempts to speak to the father and the cousin's father were made but were unsuccessful. Safety Assessments and the RAP were completed timely and accurately. MCDSS contacted relevant collaterals, including school staff, the children's pediatricians, and the placement diversion program.

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

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/15/2020	Sibling, Male, 13 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 13 Years	Mother, Female, 31 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
Two SCRs reports received by OCDSS alleged that the now 14-year-old sibling had a history of problematic behavior and becoming physically violent towards the mother. The mother had a history of being unable to adequately address the sibling's behavior and becoming physically aggressive towards the sibling. On 12/15/20, the sibling pulled the mother's hair and punched her. The mother hit the sibling in the head with a glass olive oil bottle. The sibling sustained a laceration to the left side of the forehead as a result.

Report Determination: Unfounded **Date of Determination:** 02/23/2021

Basis for Determination:
OCDSS had a lack of credible evidence to substantiate the allegations. The mother confronted the sibling about charging money to a credit card and the sibling began hitting the mother and pulling her hair. The mother said she was afraid of the sibling so she hit him in the forehead with a glass olive oil bottle in self defense. The sibling sustained a laceration to his forehead and the mother was charged with Endangering the Welfare of a Child and Assault based on a mandatory arrest law. The law enforcement officer reported the mother's actions appeared to be in self defense and the mother had no malicious intent to hurt the sibling. The sibling moved in with the maternal grandmother.

OCFS Review Results:
OCDSS assessed the safety of the mother's and grandmother's homes and they interviewed the mother, grandmother and children. Safety Assessments and the RAP were completed timely and accurately. The parents were provided with Notice of Existence timely; however, attempts to interview the father were not documented. There were no full interviews conducted with the children in order to assess overall safety and risk. Interviews were brief and allegation specific. Relevant collaterals were contacted, including family members, the pediatrician and law enforcement.

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

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

Summary:
OCDSS added the father to the report and notified about him the investigation; however, attempts to interview him were not documented. The children were only spoken to regarding the allegations. There were no full interviews conducted with the children in order to assess overall safety and risk.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

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) 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.

[redacted]

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

An SCR report dated 10/27/15 was tracked FAR with the allegations of Inadequate Guardianship against the mother's partner regarding his now 16-year-old child.

An SCR report dated 3/21/16 was unsubstantiated against the father for the allegations of Inadequate Guardianship and Lack of Supervision regarding the now 14-year-old sibling and Inadequate Guardianship regarding the now 6-year-old sibling.

An SCR report dated 10/11/17 was tracked FAR with the allegations of Educational Neglect against the mother and father regarding the subject child.

An SCR report dated 3/29/18 was unsubstantiated for the allegation of Inadequate Guardianship against the mother's partner regarding his now 5-year-old child and another child.

An SCR report dated 10/11/18 was tracked FAR with the allegations of Inadequate Guardianship against the mother and father regarding the four children and for Lacerations/Bruises/Welts regarding the subject child. The case was deemed FAR ineligible and closed when the 11/8/18 SCR report was received.

An SCR report dated 11/8/18 was unsubstantiated for the allegations of Inadequate Guardianship against the mother and father regarding the now 14-year-old sibling and the subject child and Lacerations/Bruises/Welts regarding the now 14-year-old sibling.

Known CPS History Outside of NYS

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

Preventive Services History

A Preventive Services case opened on 10/25/18, due to the now 14-year-old sibling displaying behavioral concerns at home and at school. The mother and sibling received school and community based services. The preventive services case closed on 10/8/19, at the request of the mother. At the time the case closed, the sibling was receiving home health care, diversion services, education advocacy services and mental health counseling.

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