Child Fatality Report

Report Identification Number: SY-22-020

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

Issue Date: Oct 17, 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	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 21 day(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 04/23/2022
Initial Date OCFS Notified: 04/23/2022

Presenting Information

Onondaga County Department of Children and Family Services (OCDCFS) received an SCR report on 4/23/2022 which alleged that the mother (SM) was co-sleeping with the 21-day-old child (SC). The mother awoke to find the child gasping for air and not responsive. The mother potentially waited 30 minutes to seek additional medical attention and the child died as a result. The condition of the home was also a hazard to the health and safety of the 9-year-old, 5-year-old and 1-year-old surviving siblings and there was not a clear egress in case of emergency. The role of the father (BF) was unknown.

Executive Summary

This report concerns the death of a 21-day-old child which occurred while in the care of his mother. The mother placed the child in a swaddle blanket with his arms inside and then put him on his back on a shared sleeping space of blankets and pillows on the floor with her.

OCDCFS coordinated their response with law enforcement and conducted an interview of the mother together. The mother was not clear on the timeline of events when she woke up and found the child unresponsive. The mother stated she put the child to sleep with her and awoke between 3:00-3:15 AM. The child was near to her shoulders when placed to sleep. The mother stated she found the child in a different position than she placed him to sleep in, and he was closer to her legs. The mother immediately began CPR and stated the child was gasping for air. The mother called 911 and law enforcement was first on scene at 3:35 AM and took over CPR from the mother until the ambulance arrived. It was believed by law enforcement and the medical examiner investigator the mother woke closer to 3:15 AM, found the child unresponsive, initiated CPR, and called 911. Law enforcement believed there to have been no criminality in the delay of calling 911, nor would emergency services arriving sooner prevented the child's death. The medical examiner investigator believed the mother's statement regarding the child gasping for air was actually the sound of air entering the child's lungs from CPR, and not a sign of life due to the condition of rigor the child was in upon emergency services arrival.

The 9 and 5-year-old siblings were interviewed and reported no knowledge of the fatal incident as they were asleep through most of it. The siblings did state the mother often co-slept with the 21-day-old child. The 1-year-old sibling was seen and assessed as safe in the care of the mother. The concerns reported for the condition of the home were addressed by the mother and corresponding allegations of Inadequate Guardianship and Inadequate Food, Clothing, Shelter regarding the siblings were unsubstantiated. A safety plan was not required to address the condition of the home upon the initial contact.

The father was not present in the home the night of the fatal incident and worked out of town. The father stated he was on the phone with the mother the night of the fatal incident and they both fell asleep while speaking. The father stated he awoke to the mother yelling something was wrong with the child and she ended their call to dial 911. The father expressed no other concerns for the siblings in the care of the mother.

The allegations of DOA/Fatality and Inadequate Guardianship against the mother regarding the 21-day-old child were substantiated. The cause of death was identified by the medical examiner as Accidental Death due to Unsafe Sleep Conditions. The allegation of Lack of Medical Care against the mother regarding the 21-day-old child was unsubstantiated as it was believed there was not a long delay in the mother finding the child unresponsive and calling 911 as initially reported to the SCR. The allegations against the mother regarding the surviving siblings and the conditions of the home

were unsubstantiated as the concerns were addressed by the mother. Services in relation to the death of the child were offered and declined by the family, citing they would utilize existing providers.

PIP Requirement
OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDCFS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDCFS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

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 is detailed documentation in the case record of supervisory consult throughout the investigation.

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: 04/23/2022 **Time of Death:** 04:21 AM

Time of fatal incident, if different than time of death: 02:50 AM

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 03:33 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used 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	21 Day(s)
Deceased Child's Household	Father	No Role	Male	50 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	9 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Year(s)

LDSS Response

OCDCFS received the SCR report, notified the ME and district attorney (DA) of their involvement, and coordinated their response with LE. LE informed OCDCFS the SM was co-sleeping with the SC on top of blankets and pillows on the floor of the bedroom. The SC was placed to sleep in a swaddle blanket with his arms secured inside. The SC was put to sleep on his back, near to the SM's shoulders, approximately 18 inches from where the SM was asleep. The SM woke to find the SC in a different position closer to her legs and unresponsive. The SC's face was not covered by the swaddle blanket. The SM initiated CPR and stated she could feel the SC gasping for air. LE and the ME investigator on scene reported it was likely the SM perceived the sound of air entering the lungs from CPR as gasping, and the SC was most likely deceased upon the SM waking up and finding him. The call was made to 911 at 3:33 AM and LE was on the scene at 3:35 AM. A bassinet was observed in the home. The bassinet had blankets inside which appeared to cushion the sleeping area. The SM stated the SC slept in the bassinet or with her.

OCDCFS interviewed the SM with LE. The SM confirmed the story as reported to OCDSS by LE. The SM stated she slept on blankets and pillows on the floor to assist with a previous back injury. The SM's timeline of events was unclear, though it appeared the SM woke at approximately 3:15 AM and found the SC unresponsive. The SM attempted CPR and called

911 in a much shorter gap than stated in the SCR report.

The SSs were interviewed and expressed no knowledge of the fatal incident. The 9 and 5-year-old SSs stated they were asleep and woke to the police in the home. The SSs did state the SC often slept in the bed with the SM or the bassinet next to her bed. The SSs disclosed no other concerns. The home was observed to be cluttered with no clear egress from the home in case of emergency during the initial home visit. The SM addressed the condition of the home during the investigation period.

The BF was interviewed by phone and in-person by a secondary jurisdiction. The BF stated he works out of town and was on the phone with the SM the night of the fatal incident. The BF stated they both fell asleep while on the phone and he awoke to the SM screaming when she found the SC unresponsive. The SM hung up on him to call 911, and then called him back later to inform him the SC had passed away. The BF expressed no concerns for the SSs in the care of the SM.

OCDCFS interviewed LE and the ME. The cause of death was identified as Accidental Death due to Unsafe Sleep Conditions by the ME. LE stated they would not be pursuing criminal charges and their investigation was closed. LE stated the discrepancies in the reported time between the SM finding the SC unresponsive and calling 911 varied, and they believed the SM did not wait long to call 911 after she initiated CPR.

Services were offered to all the family members in relation to the death of the SC. The services were declined, and the SM stated she would continue to utilize her previously existing provider. The family did accept financial assistance for the funeral costs.

The allegations of DOA/Fatality and IG against the SM regarding the SC were substantiated due to the SM co-sleeping with the SC and the evidence from the ME that the death of the SC was directly related to co-sleeping. The allegation of LMC against the SM regarding the SC was unsubstantiated as it was believed the SM called for assistance sooner than reported. Allegations against the SM regarding the SC and SSs for the condition of the home were unsubstantiated as the SM addressed the concerns.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: Undetermined if injury or 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: Onondaga County has an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061405 - Deceased Child, Male, 21 Days	061406 - Mother, Female, 36 Year(s)	DOA / Fatality	Substantiated
061405 - Deceased Child, Male, 21 Days	061406 - Mother, Female, 36 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated

061405 - Deceased Child, Male, 21 Days	061406 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
061405 - Deceased Child, Male, 21 Days	061406 - Mother, Female, 36 Year(s)	Lack of Medical Care	Unsubstantiated
061408 - Sibling, Female, 9 Year(s)	061406 - Mother, Female, 36 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
061408 - Sibling, Female, 9 Year(s)	061406 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
061409 - Sibling, Female, 5 Year(s)	061406 - Mother, Female, 36 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
061409 - Sibling, Female, 5 Year(s)	061406 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
061410 - Sibling, Female, 1 Year(s)	061406 - Mother, Female, 36 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
061410 - Sibling, Female, 1 Year(s)	061406 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated

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 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? No
Explain:
Services were offered on behalf of the SSs and declined by the family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered in relation to the death of the SC and declined by the family.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

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)
03/24/2022	Sibling, Female, 9 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 4 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged the SM hit the 9, 4, and 1-year-old SSs with a belt as a form of punishment causing pain to the children. The role of the father was unknown. The SC was born during the open investigation.

Report Determination: Unfounded **Date of Determination:** 06/13/2022

Basis for Determination:
OCDCFS interviewed the family and obtained information from relevant collateral sources. The children did not make a disclosure of physical discipline occurring in the home. Collateral sources believed the SSs were not being truthful in their interviews with OCDCFS and the SM was counseled on appropriate forms of discipline.

OCFS Review Results:
OCDCFS interviewed all family members and obtained information from relevant collateral sources. The allegations in the SCR report were unsubstantiated due to a lack of evidence, though OCDCFS noted the collateral sources did not believe the SSs were truthful in interviews with OCDCFS . The SC was born and passed away during the open investigation and his death was investigated in a separate case.

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

Issue:
Failure to provide safe sleep education/information

Summary:
OCDCFS documented the SM as being pregnant during the investigation and did not provide materials on safe sleep education as required.

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

Action:

OCDCFS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/22/2021	Sibling, Female, 9 Years	Mother, Female, 35 Years	Excessive Corporal Punishment	Unsubstantiated	Yes
	Sibling, Female, 9 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 35 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The SCR report alleged the SM was hitting the then 9-year-old SS with a belt as a form of punishment and locked the SS in her room overnight. The 9-year-old child had sustained bruises as a result of the physical discipline. The roles of the father and the then 4-year-old sibling and 1-year-old sibling were unknown.

Report Determination: Unfounded **Date of Determination:** 11/23/2021

Basis for Determination:
OCDCFS interviewed all family members and no disclosures of physical discipline were made. The SM stated she threatened to use a belt, though denied ever using it. The family stated the SSs were not locked in their rooms as reported and showed OCDCFS the SSs share a room and a baby gate was present, though the elder siblings were able to step over it and exit the room when they wanted.

OCFS Review Results:
OCDCFS interviewed all family members and relevant collateral sources. A list of service providers was given to the SM to address the difficult behaviors of the then 9-year-old SS as it was believed she had a different view of family interactions than the rest of the family and was reporting information incorrectly.

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

Issue:
Failure to provide safe sleep education/information

Summary:
OCDCFS observed the 1-year-old SS in the home and documented the SM as being pregnant during the investigation and did not provide materials on safe sleep education as required.

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

Action:
OCDCFS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/19/2020	Sibling, Female, 7 Years	Father, Male, 47 Years	Sexual Abuse	Unsubstantiated	Yes

Report Summary:
The SCR report alleged the BF took a shower with the then 7-year-old SS and kissed and hugged her in a sexual manner.

Report Determination: Unfounded | **Date of Determination:** 01/21/2020

Basis for Determination:
OCDCFS and LE interviewed all family members together. The 7-year-old SS was describing a time the BF bathed her when she was approximately 3-years-old and helped her in the bath, but was not in the bath with her. The BF denied the allegations and stated he stopped bathing the siblings each child when they were around 1 year old. The SM, BF, and SSs denied the children had seen the BF naked and no disclosures of inappropriate interactions were made.

OCFS Review Results:
OCDCFS interviewed the family members and obtained information from relevant collateral sources. No evidence of inappropriate interactions was uncovered in the investigation and LE did not pursue criminal charges. The SM was documented as being pregnant and a referral was made to Healthy Families.

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

Issue:
Failure to provide safe sleep education/information

Summary:
OCDCFS documented the SM as being pregnant during the investigation and did not provide materials on safe sleep education as required.

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

Action:
OCDCFS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

[redacted]

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

The BF was named in a COI in February 2008 in which a maternal aunt was applying for custody of his then 15-year-old child while the BF was incarcerated.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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