Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-24-037

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

Issue Date: Dec 31, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 9 year(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 08/22/2024
Initial Date OCFS Notified: 08/26/2024

Presenting Information

On 8/22/24, at approximately 2:20AM, the mother was operating a vehicle while under the influence of methamphetamines with the subject child present. The mother drove the wrong way on the highway which resulted in a head-on, multi-car crash. In the accident, the subject child sustained blunt force trauma to the head and became unresponsive. The subject child was transported to the hospital by Emergency Medical Services while life-saving measures were performed. The subject child was pronounced deceased upon arrival at the hospital.

Executive Summary

This fatality report concerns the death of the 9-year-old subject child that occurred on 8/22/24. On 8/26/24, the Suffolk County Department of Social Services (SCDSS) received a report regarding the fatality. At the time of death, the subject child lived with the subject mother.

On 8/22/24, at approximately 8:30-9PM, the mother and subject child went for a ride to get food. The subject child fell asleep in the back of the car, and due to a medical diagnosis preventing him from sleeping in the days leading up to the accident, the mother drove around so he could continue to sleep. During the drive, the mother became disoriented and was unable to find the correct route home. While driving, the mother became tired; she pulled over on a side road and slept for an unknown amount of time before continuing the drive home. The mother stated the road was dark and she was disoriented, so she did not know she was going the wrong way on the highway. The mother denied using any illegal substances or misusing prescriptions.

Following the multi-vehicle car crash, the mother was taken to the hospital and cleared medically before being taken to the police station for questioning. The mother was arrested and charged with Endangering the Welfare of a Child, Murder, Murder in 2nd degree, Vehicular Manslaughter, Driving a Vehicle while Impaired by Drugs, Criminal Possession of a Controlled Substance, Fleeing an Officer, Aggravated DWI with a Child in the car, and multiple traffic violations.

SCDSS contacted the Medical Examiner who stated the subject child's cause of death was multiple blunt force injuries, including complete transection of lower cervical vertebrae with complete transection of the lower spinal cord in the cervical spine. The manner of death was homicide.

SCDSS made the appropriate determination to substantiate allegations of DOA/Fatality, Inadequate Guardianship, Internal Injuries, and Parents Drug/Alcohol Misuse against the subject mother.

SCDSS offered bereavement services and burial assistance to the father, the father's partner, maternal grandmother, and 2 adult siblings. SCDSS made diligent efforts to assist with facilitating bereavement and mental health services to the mother who remained incarcerated after her arrest.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on**

the:

- **Safety assessment due at the time of determination?** N/A

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 were no surviving siblings in the home, therefore, safety assessments were not required.

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: 08/22/2024 **Time of Death:** 02:55 AM

Time of fatal incident, if different than time of death: 02:20 AM

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	9 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)

LDSS Response

On 8/26/24, SCDSS received an SCR report regarding the death of the SC. SCDSS initiated the investigation within 24hrs and coordinated efforts with LE. The source was spoken to, the DA was contacted, and all relevant collateral contacts were made. There were no surviving siblings in the home.

The SM was interviewed and stated that on 8/22/24, she and the SC had left the home to get food around 8:30-9PM. The SM stated the SC had not been sleeping well the days leading up to the incident, so when he fell asleep in the back seat of the car, she drove around for over an hour to allow him time to sleep. While driving, the SM stated a white van began to follow her closely, and she believed the vehicle was trying to drive her off the road. At approximately 9:30PM, the SM called 911 to report the incident and was instructed to pull over and wait for a patrol car. The SM was too afraid to pull over and declined the dispatchers offer of assistance. The SM started driving towards the maternal grandmother's residence; however, she was tired, so she pulled over and slept in the vehicle for an unknown amount of time. The SM stated she was disoriented upon waking; however, she began the drive home. The SM stated her GPS was not working, so she could not get directions. The SM stated she drove for a couple of hours and began to feel tired but was too afraid to pull over, and there were cars beeping at her because "she was going so slow in the right lane." The SM stated she did not remember much other than a police car coming up behind her vehicle and hitting her back bumper. The SM became panicked when her left leg became stiff, and she was unable to move it off the gas pedal. The SM did not recall if she was driving the wrong way, and stated "the road was very dark, and the exits were confusing even with the red wrong way signs."

SCDSS interviewed the BF who stated he had not seen the SC since he was 3yo. The BF was unable to see the SC due to a full order of protection in place until 3/25/31; the result of a domestic violence incident between the BF and the SM, which he said did not happen. The BF stated he had filed a petition for custody and visitation in 2020 as he did not feel the SC was safe with the SM. The BF stated the case was postponed due to the pandemic and was closed without a resolution. The BF stated that he expressed concerns regarding the SM's mental health and substance misuse to CPS during previous investigations. The BF's family was interviewed, a 1-month-old half-sibling was assessed as safe, and the family accepted referrals for bereavement services.

SCDSS interviewed LE who were at the scene of the accident. LE reported that on arrival, the SM was observed standing next to the driver's side door and the SC was in the back seat with his seat belt on. Responding officers stated they immediately attended to the SC, removing him from the back seat and placing him in front of the vehicle. The SC had a large laceration on the left side of his forehead; he was unconscious, unresponsive, and did not have a pulse. LE started CPR and continued until EMS arrived approximately 8 minutes later and transported the SC to the hospital. LE stated the SM displayed no emotion at the scene; she exhibited a dull, flat affect. The SM failed the field sobriety test; however, had a 0.0 blood alcohol level. LE described the SM as "delusional," and reported she was "making comments that made no sense." A prescription bottle was found at the scene with 4.4mg of amphetamines. The SM was taken to the hospital and assessed by a Drug Recognition Expert who informed LE the SM was under the influence of "some type of stimulant." At the hospital, the SM stated, "Jeffrey Epstein was trying to kidnap me and [the subject child]." Once medically cleared the SM was taken in for questioning and arrested. The case record indicated the SM signed releases for her mental health providers; however, the information had not been received by the time the case closed.

SCDSS contacted relevant collateral sources, and medical documentation was requested from the pediatrician; however, records had not been received when the case closed. Bereavement services and burial assistance were offered to the family, but it was unknown if they were used. The BF declined additional services, the case was indicated and closed.

Official Manner and Cause of Death

Official Manner: Homicide
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?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
068481 - Deceased Child, Male, 9 Year(s)	069573 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
068481 - Deceased Child, Male, 9 Year(s)	069573 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
068481 - Deceased Child, Male, 9 Year(s)	069573 - Mother, Female, 32 Year(s)	Internal Injuries	Substantiated
068481 - Deceased Child, Male, 9 Year(s)	069573 - Mother, Female, 32 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
School	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Mother	Unknown	Unknown
Comments:	As a result of the fatality, the mother was charged with Murder, Murder in the 2nd, Endangering the Welfare of a Child, Vehicular Manslaughter, Operating a Vehicle while Impaired by Drugs, Criminal Possession of a Controlled Substances, Fleeing an Officer, Aggravated DWI with a Child in the Car, and multiple traffic violations.		

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:
The mother was arrested following the fatal incident and remained incarcerated when the investigation closed. There were no surviving siblings in the home.

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? N/A
Explain:
There were no surviving siblings in the household.

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:
The father, the father's partner, the 2 adult siblings, and the maternal grandmother were offered referrals for bereavement services. SCDSS made efforts to arrange bereavement and mental health services for the mother while she was incarcerated.

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? 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)

05/09/2023	Deceased Child, Male, 7 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 7 Years	Mother, Female, 31 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The SM used physical discipline on the SC for several years resulting in the SC obtaining bruises and feeling unsafe in the home.

Report Determination: Unfounded | **Date of Determination:** 06/05/2023

Basis for Determination:
The case was unfounded due to the lack of a fair preponderance of evidence. The SM and SC both denied the use of physical discipline. During an interview, the SC reported he felt safe in the home and was observed to be free of any marks and bruises.

OCFS Review Results:
Diligent efforts were made to interview the SM, BF, and SC. SCDSS documented concerns in the case record regarding the SM's mental health; however, these concerns were not reflected in the Risk Assessment Profile. This change would not affect the final risk rating.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/13/2023	Deceased Child, Male, 7 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The SM was experiencing serious mental health concerns while acting as the sole caretaker of the then 7yo SC. On 1/12/23, the SM was wandering the streets, experiencing auditory hallucinations, paranoia, and delusions. The SM experienced rage, and was unable to provide adequate care of the SC. The SM was unemployed, unable to maintain the home, and it was unknown if she was receiving any assistance.

Report Determination: Unfounded | **Date of Determination:** 04/17/2023

Basis for Determination:
The SM was taken to the hospital where she received a mental health diagnosis. While there, it was proposed an infection was also a possible cause of the behavioral changes. SCDSS determined there was not a fair preponderance of evidence to support the allegations, and the SC was not placed in physical, emotional, or mental harm. The SC stayed with the MGM temporarily while the SM was hospitalized and was returned to the SM's care upon her discharge. Furthermore, the MGM and MGF had a planned vacation which prevented the SC from remaining in their care, which was the original safety plan documented in the case record. The case was closed when SCDSS concluded CPS was no longer needed.

OCFS Review Results:
Upon receipt of the report, SCDSS made diligent efforts to establish face-to-face contact with the SC to assess safety. Despite SCDSS having created a safety plan with the maternal grandparents, it was not documented in the safety assessment, nor were any safety factors marked as present. There was no documentation in the case record of SCDSS attempting to contact the fire station that the SM reportedly wandered into. There was no documentation in the case record of casework contacts with the family from 2/23/23-3/30/23. During the initial interview with the SC, he expressed he, "kind of, a little bit feels safe," and reported that the SM sometimes hears voices. The case record did not reflect that the SC was asked about the events of the night, and if he had been with her when she was reported to be walking in the road and into a fire station.

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

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The safety assessment completed by SCDSS did not accurately reflect the safety factors present. SCDSS marked there were no safety factors present in the initial assessment, despite the SM being hospitalized for mental health concerns, and collateral sources reporting the SM was not safe for discharge. The safety plan was not documented in the initial assessment. Additionally, the final safety assessment was scored for having no safety factors, despite the SM discontinuing medication against medical advice, and not engaging in mental health services which contradicted the hospital's discharge plan.

Legal Reference:

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

Action:

The results for each Safety Assessment will be accurately documented in the case record to reflect case circumstances regarding safety.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP was scored that the SM did not have mental health concerns, despite having been hospitalized, receiving a diagnosis, and being prescribed medications. Additionally, the RAP was scored 'no' for issues with housing, despite the home being in foreclosure, and 'yes' for understanding the seriousness of the current/potential harm and willing to address any areas of concern.

Legal Reference:

18 NYCRR 432.2(d)

Action:

SCDSS will consider all elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

The case record did not reflect casework contact between 2/23/23-3/30/23. The family accepted bereavement referrals on 2/23/23; however, SCDSS did not provide the information until 4/4/23. SCDSS missed opportunities to gather additional information from collaterals, such as the fire station the SM had 'wandered into.' Despite prior plans and directives for the SM to follow MH recommendations and engage in medication management, the case was closed and unfounded without confirmation of the SM's engagement in services. There was no follow up with the SC regarding his initial comments about "bad people doing bad stuff" in the home.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

SCDSS will document all applicable actions and considerations with respect to safety planning, including but not limited to including all family members when devising the plan, adequately monitoring the plan, and consulting with the legal department if there is a reason to believe the safety plan may not be sufficient to protect the children.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The case record does not reflect the SC was asked if he was with the SM the night of the alleged incident, and if so, his description of what transpired. There were no follow up interviews that included questions regarding the voices the SC reported he hears, the SM hearing voices, or clarification regarding the SC feeling safe. The SC reported "bad things" happen in the family home; however, there were no follow up discussions in regard to this statement.

Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
In addition to the conditions enumerated in the report, CPS is required to determine any other condition that may constitute abuse or maltreatment. SCDSS 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:
Failure to Offer Appropriate Services
Summary:
SCDSS did not offer services to the SM despite ongoing mental health concerns. Additionally, the SM expressed having difficulty obtaining a different provider and displayed erratic behavior during casework contacts.
Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
When service needs are identified, SCDSS will make the appropriate referral to Preventive Services in an effort to determine whether there are services that can benefit the family.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/11/2022	Deceased Child, Male, 6 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Deceased Child, Male, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 6 Years	Mother, Female, 30 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 6 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The SM was using an illegal substance to impairment on a daily basis while acting as the sole caregiver of the SC. While misusing substances, the SM became delusional and paranoid and left the then 6yo SC unsupervised. Due to this the SC missed meals and was regularly hungry.

Report Determination: Unfounded | **Date of Determination:** 05/27/2022

Basis for Determination:
There was not a fair preponderance of evidence to support the allegations of IG, IF/C/S, PD/AM and LS against the SM. The SC was interviewed and denied being left alone, not eating regularly, and observing the SM using any substances. The SM stated there was a friend staying temporarily in the garage who was found to be using illegal and selling illegal substances from the home. An Order of Protection was obtained against the friend.

OCFS Review Results:
SCDSS made efforts to contact the BF, and made adequate contacts with the SM and SC. Safety assessments were adequate; however, the RAP was incorrectly scored 'no' for caretaker having been a victim or perpetrator of abusive or threatening incidents with partners or other adults/family in the neighborhood. This error would not impact the final risk rating. The case was appropriately closed and unfounded.

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

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

5/30/18-7/10/18 Investigation included allegations of Inadequate Guardianship (IG) against the SM was unfounded (UNF).

1/21/19-2/15/19 Allegations included IG against the SM and BF, and Parent Drug/ Alcohol Misuse against the BF. A neglect petition was filed against the BF in family court and a complete stay away Order of Protection was obtained by the SM, expiring in 2030. Preventive Services case was opened, and the SC was released to the SM. The investigation was Indicated.

1/4/21-2/26/21 Investigation included allegations of IG against the SM was UNF.

10/5/21-12/06/21 Investigation included allegations of IG and Lack of Supervision against the SM and her boyfriend. The SCR report included allegations the SM and her boyfriend were selling methamphetamines in the presence of the SC and misusing substances to impairment while acting as sole caregivers. The case was UNF.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A Preventive Services case was open from 1/31/19 to 9/26/19. The case was opened after a physical altercation occurred between the parents. The BF returned to the home intoxicated and hit the SM while she was holding the SC, and the SM threw items at the BF. The BF was arrested and charged, and a full stay away Order of Protection was issued. The SC was released to the SM with court ordered supervision. SCDSS provided Preventive Services. The SM engaged in recommended services and the BF was incarcerated. The BF stipulated to neglect, which was vacated when the BF consented to the SM's custody petition. The case was closed when custody was established.

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