Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-24-039

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

Issue Date: Feb 10, 2025

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

- ☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
- ☐ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.
- ☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
- ☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Chenango
Gender: Female
Date of Death: 09/04/2024
Initial Date OCFS Notified: 09/04/2024

Presenting Information

An SCR report alleged that on 9/4/24, the 2-year-old subject child was not properly supervised and ran into the driveway as the father was moving his car. The father's car struck the subject child while he was completing a 3-point turn. The subject child obtained trauma to her head, and was bleeding from the head, chest, and face. The mother called 911 and the father performed CPR until EMS arrived. EMS took over life-saving measures on arrival, and the subject child was transported to the hospital where she was pronounced deceased.

Executive Summary

This report concerns the death of the 2-year-old female subject child that occurred on 9/4/24. A report was made to the SCR on the same day alleging the subject child was not properly supervised and ran into the driveway while the father was moving his car. As a result, the subject child was struck by the car and died at the hospital. At the time of her death, the subject child resided with the mother, father, and surviving siblings, aged 3 years, 1 year, and 2 weeks.

Chenango County Department of Social Services (CCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. A safety plan was implemented to ensure the safety of the surviving siblings, and relevant collateral contacts were made.

The investigation revealed the father was moving the car when the subject child approached the vehicle. The father did not see the subject child, and believed the children were all a safe distance away from the car. He reversed, then moved the car forward, stopping when he heard a noise and felt an impact. The father exited the vehicle to see what the noise was and found the subject child under the passenger side of the vehicle. The father removed the child from under the car and began CPR while the mother called 911. EMS continued life-saving measures while on route to the hospital where the subject child was pronounced deceased.

CCDSS completed required Safety Assessments timely and adequately, and the RAP accurately reflected case circumstances. Documentation was entered contemporaneously and with detail. The family was offered bereavement services and funeral assistance; the offers were not accepted.

The medical examiner determined the cause of death to be blunt force trauma sustained in a pedestrian-SUV collision; the manner of death was determined to be an accident. Law enforcement determined the incident was accidental and closed the case without pursuing criminal charges. The surviving siblings remained in the care of the mother and father.

The allegations of DOA/Fatality, Internal Injuries, Lacerations/Bruises/Welts, Lack of Supervision, and Inadequate Guardianship were appropriately substantiated against the mother, father, and maternal grandmother in regard to the subject child. The mother, father, and maternal grandmother failed to adequately supervise the subject child; the mother allowed the child to go back outside after using the bathroom without alerting the maternal grandmother or father. The maternal grandmother was more than an arm's length distance from the children and unable to ensure they were safeguarded. The father failed to verify the children were not near the vehicle. These actions/inactions resulted in the subject child being struck by the family car. Additional allegations of Inadequate Guardianship and Lack of Supervision were substantiated against the mother, father, and maternal grandmother in regard to the 3-year-old and 1-year-old

surviving siblings.

Preventive Services were offered to the family and declined. The case was indicated and closed.

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:
Casework activity was commensurate with case circumstances.

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:
The decision to close the case was appropriate.

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: 09/04/2024 **Time of Death:** 01:53 PM

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

County where fatality incident occurred: Chenango
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? 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	Female	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	18 Day(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	54 Year(s)

LDSS Response

On 9/4/24, CCDSS received a report regarding the death of the SC. CCDSS initiated their investigation within 24 hours, coordinated efforts with LE, contacted the source, and completed a history check. The SSs were assessed as safe with the caregivers; however, a safety plan was implemented while CCDSS obtained additional information regarding the fatal incident.

The SF stated he moved the car to clean it and reinstall the car seats. He stated the 3yo and 1yo SSs were outside playing together, and the SC went back inside to use the bathroom with the SM. The SF stated he reversed the car before pulling

forward, and he heard a “crunch." He stopped, exited the vehicle, and observed the SC under the front of the car. The SF removed the SC from under the car and began CPR. The SF denied there was music playing in the car during the incident, and stated the MGM was sitting on a chair on the patio where she had a clear view of both sides of the vehicle.

The mother stated the family was outside the morning of the incident; the SC, the 3yo, and 1yo SSs were playing together. The 2-week-old SS was sleeping inside, and the SM had gone in to take care of her when the SC came in to use the bathroom. Once the SC was finished, the SM opened the front door, and the SC went back outside. The SC was near the car and the SM stated she told the SC to move. The SF then asked the SM if the children were out of the way, which the SM stated she responded ‘yes,' as they were at that time. The SM stated when the SF pulled the car forward the SC was in the blind spot on the passenger side of the vehicle, and the SF struck her. The SM stated the MGM was outside supervising the children at the time of the fatal incident. The SM stated the SF had been turning the vehicle around to clean it and reinstall the car seats, and there was no music playing in the car. The SM immediately called 911 while the SF began CPR.

The MGM was interviewed and stated the SC, 3yo and 1yo SSs were playing outside the morning of the fatal incident. The SF got into the car to move it, and when the SC heard the engine start, she ran toward the vehicle because she loved car rides. The SF had the music turned up loud and did not hear the MGM yell for the SF to stop, and she did not make it to the SC fast enough to intervene. The MGM stated the SC was yelling for the SF to stop so she could get in the car. The SC was close to the car when the SF stopped and reversed; when he drove forward the SC went “right under the car.” The MGM stated everything happened so quickly, and she did not believe the SF was aware the SC was there. The SF stopped the car immediately, got out to check behind the vehicle, and pulled the SC out from under the car. The MGM did not believe the SC was conscious, and her neck appeared to be broken. The SF immediately started CPR, and the MGM went to help the SSs who witnessed the incident, and were calling out, “sissy, sissy, sissy.”

CCDSS interviewed a nurse who was present in the ER when the SC arrived. The nurse stated the SC was “deceased when she arrived," and the time of death was 1:53PM. The social worker at the hospital reported there were no suspicious marks on the SC other than the “tire tread like mark” across the SC’s chest. Medical records obtained from the ER stated the SC arrived with no signs of life, an obvious head injury, was bleeding from the left ear and nose, and had fixed pupils.

CCDSS made collateral contacts, including first responders, hospital staff, the pediatrician, family members, and neighbors; there were no concerns shared.

The MGM reported concerns of DV and excessive discipline; however, the children were observed to be free of marks and were assessed as safe. Referrals were offered on their behalf.

The SM and SF denied excessive corporal punishment or any past or current DV. The SM engaged in parenting classes; however, the SF and SM declined all other referrals offered by CCDSS. The case was indicated and closed.

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

Comments: The fatality was referred to an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069777 - Deceased Child, Female, 2 Year(s)	069778 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069780 - Grandparent, Female, 54 Year(s)	Lacerations / Bruises / Welts	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069779 - Father, Male, 30 Year(s)	Lack of Supervision	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069779 - Father, Male, 30 Year(s)	Lacerations / Bruises / Welts	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069778 - Mother, Female, 27 Year(s)	Lack of Supervision	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069778 - Mother, Female, 27 Year(s)	Lacerations / Bruises / Welts	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069780 - Grandparent, Female, 54 Year(s)	Lack of Supervision	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069779 - Father, Male, 30 Year(s)	Internal Injuries	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069778 - Mother, Female, 27 Year(s)	Internal Injuries	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069780 - Grandparent, Female, 54 Year(s)	DOA / Fatality	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069779 - Father, Male, 30 Year(s)	DOA / Fatality	Substantiated
069777 - Deceased Child, Female, 2 Year(s)	069780 - Grandparent, Female, 54 Year(s)	Internal Injuries	Substantiated
069781 - Sibling, Female, 3 Year(s)	069780 - Grandparent, Female, 54 Year(s)	Lack of Supervision	Substantiated
069781 - Sibling, Female, 3 Year(s)	069778 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
069781 - Sibling, Female, 3 Year(s)	069778 - Mother, Female, 27 Year(s)	Lack of Supervision	Substantiated
069781 - Sibling, Female, 3 Year(s)	069779 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
069781 - Sibling, Female, 3 Year(s)	069780 - Grandparent, Female, 54 Year(s)	Inadequate Guardianship	Substantiated
069781 - Sibling, Female, 3 Year(s)	069779 - Father, Male, 30 Year(s)	Lack of Supervision	Substantiated
069782 - Sibling, Female, 1 Year(s)	069780 - Grandparent, Female, 54 Year(s)	Inadequate Guardianship	Substantiated

069782 - Sibling, Female, 1 Year(s)	069778 - Mother, Female, 27 Year(s)	Lack of Supervision	Substantiated
069782 - Sibling, Female, 1 Year(s)	069779 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
069782 - Sibling, Female, 1 Year(s)	069778 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
069782 - Sibling, Female, 1 Year(s)	069779 - Father, Male, 30 Year(s)	Lack of Supervision	Substantiated
069782 - Sibling, Female, 1 Year(s)	069780 - Grandparent, Female, 54 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐

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:
Bereavement services and burial assistance were offered to the family; however, they were not accepted. CCDSS unsuccessfully encouraged the caregivers to engage in mental health services throughout the investigation. The mother engaged in parenting classes.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
The surviving siblings were not removed; however, a safety plan was implemented by CCDSS. The safety plan required the mother and father to be supervised with the children until "pertinent parties were interviewed and the family home was assessed as safe." On 9/12/24, the safety plan was lifted by CCDSS after collateral contacts were made and the case address was assessed as safe and appropriate for the SSs.

Legal Activity Related to the Fatality

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

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	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in

response to the fatality? Yes
Explain:
Mental health services were offered on behalf of the surviving siblings.

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:
Bereavement services were offered to the mother, father, and maternal grandmother in response to the fatality.

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)
04/08/2024	Deceased Child, Female, 2 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 2 Years	Mother, Female, 27 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 27 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 27 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Female, 2 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 2 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated	

Sibling, Female, 1 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 1 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 3 Years	Mother, Female, 27 Years	Lack of Medical Care	Unsubstantiated
Sibling, Female, 3 Years	Father, Male, 30 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
The SM and SF did not adequately supervise the SC, aged 2, and the SSs, aged 3 and 1yo. While unsupervised, the 3yo SS threw a blanket onto the stove and it caught fire. The 3yo SS pulled the blanket off the stove, and it landed on her feet, burning her. The SS required medical care; however, the caregivers failed to adequately address the situation. Additionally, the case address had exposed wires that presented a safety hazard to the children and the caregivers allowed known substance users to watch the children.

Report Determination: Unfounded | **Date of Determination:** 04/25/2024

Basis for Determination:
There was not a fair preponderance of evidence to substantiate the allegations. There were no burns observed on the 3yo SS, and the alleged substance user who babysat the children was interviewed and appeared sober. The home was observed to be clean during the home visit.

OCFS Review Results:
CCDSS took all necessary steps to ensure the children were assessed for safety. There was no documentation present in the parent/caretaker actions/safety plan tab in the Safety Assessment. Despite a history of concerns regarding safety/hygiene of the case address, there was little to no information regarding the home in the progress notes. Additionally, there was information noted in the Safety Assessment that was not present elsewhere in the case record. The RAP was marked 'no' for the presence of DV despite the SM previously reporting DV between herself and the SF. This casework practice issue was cited in a previous case and will not be cited again.

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

Issue:

Adequacy of Progress Notes

Summary:

There were insufficient progress notes from home visits. The 7-Day Safety Assessment stated that "during an unannounced HV to the home, CCDSS could see through the curtain that the home did appear dirty/cluttered." There was no description of the case address in the progress note from that visit. Additionally, there was no documentation regarding the exposed wires alleged in the report.

Legal Reference:

18 NYCRR 428.5

Action:

CCDSS will accurately document all casework activity into progress notes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/18/2023	Deceased Child, Female, 1 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes

Sibling, Female, 3 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 6 Months	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 3 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 6 Months	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
The SM and SF failed to properly clean the 6-month-old SS's diapers, only changing it once or twice a day. As a result, the 6-month-old SS's health was impacted. The case address had food all over the floor, and the then 3yo SS and 1yo SC ate the old food off the floor. The 3yo was allowed to drink energy drinks, and all 3 children were not regularly bathed. The SM and SF historically engaged in mutual physical altercations in the presence of the children.

Report Determination: Unfounded | **Date of Determination:** 12/15/2023

Basis for Determination:
There was not a fair preponderance of evidence to substantiate allegations of IG against the SM and SF. The 6-month-old SS was found to be free of any diaper rashes, and the home was found to be messy; however, there were no safety concerns, and the home was cleaned by the next home visit. The SM and SF denied the 3yo SS drank energy drinks.

OCFS Review Results:
The investigation was completed timely, and the Safety Assessments and the RAP were adequate. However, the case was closed before the medical information was obtained, despite the allegations including the 6-month-old SS had medical issues due to the caregivers not attending to the SS's hygiene needs.

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

There were missed opportunities to obtain information from the pediatrician to address the concern regarding the 6-month-old SS's alleged medical issues. CCDSS obtained multiple releases that would allow them to access the children's medical records; however, the case record shows the case was closed before the information was received.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

CCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and determination of allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/21/2023	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 2 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Female, 2 Months	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 1 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 2 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 2 Months	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
The SM and SF did not provide adequate care for the hygiene of the 6-week-old SS which resulted in a bleeding diaper rash. The home was alleged to be unsanitary, with dirty diapers and old food strewn across the floor which the children ate from. The SM left the children unsupervised in the home while she went outside and regularly propped the bottle for the 6-week-old sibling.

Report Determination: Unfounded | **Date of Determination:** 07/13/2023

Basis for Determination:
During the initial home visit, the allegations were confirmed; there was dirty diapers, old food, and other items strewn across the floor. The conditions were corrected by caregivers, and during subsequent home visits the home was found to meet minimum degree of care. The 6-week-old SS was observed to have diaper rash; however, it was not bleeding. The SM obtained a prescription medication from the pediatrician to treat the rash, and the rash was almost healed by the final home visit. The case was unfounded and closed.

OCFS Review Results:
CCDSS made adequate collateral contacts and notes were entered contemporaneously; however, the Safety Assessment and RAP were incorrectly scored. CCDSS noted, “During an unannounced home visit regarding the current report, the floors of the home were excessively cluttered and dirty with piles of old food/snacks and other items accessible to the children. The next day, [the SM] did have the floors cleaned however she does not address the concerns until after CPS intervenes.” This was not the family's first report with these concerns; however, there was no documentation in the case record that any services were offered.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The Risk Assessment Profile was incorrectly scored 'no' for caretaker has been a victim or perpetrator of abusive or threatening incidents with partners/other adults. The RAP was scored 'yes' for caretaker has developmentally appropriate expectations of the children, even though the home was found to be dirty, and various items were strewn about the floor and accessible to the young children.

Legal Reference:
18 NYCRR 432.2(d)

Action:
CCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Appropriateness of allegation determination

Summary:

CCDSS justified unsubstantiating allegations of IG by stating the home was found to have items and food on the floor that could cause the two young children, who are at an age when they put things in their mouths, and could choke; however, the SM and SF corrected the safety issue after CPS intervened. However, the children were at imminent risk of harm prior to CPS intervention.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

CCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Syracuse Regional Office if further guidance is needed.

Issue:

Failure to Offer Appropriate Services

Summary:

Despite CCDSS documenting the family has received more than one report with concerns regarding the safety and hygiene of the home, in addition to other needs that were revealed during the investigation, there was no documentation in the case record of services that were offered to the family.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation conducted, CCDSS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/27/2022	Deceased Child, Female, 5 Months	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 1 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

The case address was a below minimum degree of care and had garbage, clothing, chicken feces, and debris strewn across the floors making it difficult to walk through. There was a foul odor present, and the sink contained trash, old food, and dirty dishes. The children were reported to have poor hygiene, and there were no working smoke detectors present in the home.

Report Determination: Unfounded

Date of Determination: 08/09/2022

Basis for Determination:

The SF initially denied CCDSS access to the home; however, the SM made a plan for her and the children to stay in another location until the home was cleaned. The SF allowed CCDSS into the home 4 days later, and the home was observed to meet the minimum degree of care. The family moved into another residence before the CPS investigation was closed, which was assessed as safe and appropriate for the children. Referrals were made to community services; however, the family declined additional offers of assistance. The case was unfounded and closed.

OCFS Review Results:

CCDSS initiated the investigation timely, assessed the safety of the children, and made ample collateral contacts. CCDSS identified the needs of the family and provided appropriate referrals. The investigation was closed timely and appropriately unfounded.

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

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

The MGM had a history of CPS involvement more than three years prior to the fatality which included:

A FAR case in 2010 with concerns of Educational Neglect regarding children in the household. The case was closed.

An investigation in 2013 contained allegations of Inadequate Guardianship and Sexual Abuse that were substantiated against the MGM and her then partner regarding two children living in the home. The MGM was aware of the sexual abuse that occurred between the partner and the children; however, the MGM left the children in his sole care for six months. When the MGM lived in the home, she failed to act on behalf of the children.

An investigation in 2014 contained unsubstantiated allegations of Inadequate Guardianship and Child's Drug/Alcohol Use against the MGM.

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