Child Fatality Report

Report Identification Number: SY-24-045

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

Issue Date: Apr 22, 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: 1 month(s)
Jurisdiction: Madison
Gender: Male
Date of Death: 11/02/2024
Initial Date OCFS Notified: 11/02/2024

Presenting Information

On 11/2/24, an SCR report alleged the father fell asleep with the child on his chest while the mother was present. The father woke to find the child cold and not breathing. The parents attempted CPR and called 911. EMS transported the child to the hospital, where he was pronounced deceased. It was believed unsafe sleep contributed to the death. Two subsequent reports were received. One alleged the parents had been intoxicated, engaged in an altercation, and were unable to care for the child. The father drove away with the child and the mother failed to intervene. The father passed out on the couch with the child and when the mother returned home, she found the child cold and called her parents. It was unknown who called 911. First responders arrived; however, no life-saving measures were taken. The child was declared deceased at the home. The child was smothered to death by the father. The second alleged the mother had been out completing errands and returned to find the child dead.

Executive Summary

This report concerns the death of the 1-month-old subject child. Madison County Department of Social Services (MCDSS) received an SCR report regarding the subject child's death on 11/2/24, and two subsequent reports on 11/5/24. At the time of the subject child's death, he was residing with his mother and father. There were two surviving siblings, ages 8 and 11 years, who resided with their mother, mother's paramour, and 1-year-old sibling. MCDSS assessed the surviving siblings to be safe.

MCDSS spoke with the parents who reported the subject mother had gone out with friends while the subject father remained home with the subject child. The mother returned home to find the father asleep on the couch with the subject child stuck between the father's body and the couch. The subject child was not breathing. EMS transported the subject child to the hospital, where he was pronounced deceased.

MCDSS received the preliminary autopsy report from the medical examiner. The preliminary report revealed that there had been medical intervention, that no trauma contributed to the subject child's death, and that the subject child had no gross apparent conditions or diseases. A radiological skeletal survey was negative for fractures. The final autopsy report was pending at the time of case closure.

MCDSS coordinated their investigation with law enforcement. Law enforcement did not plan to press charges against the father as it did not appear the cause of death was purposeful or malicious, and the incident appeared to be an accident due to unsafe sleep conditions. Law enforcement was waiting to receive the final autopsy report before closing their case.

MCDSS provided the parents with resources for bereavement services and support groups. The parents accepted the resources; however, they declined the services. The mother reported she planned to engage in therapy with her previous mental health provider.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
The allegations DOA and IG against the subject father were appropriately substantiated.

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:
Casework activity was commensurate with case circumstances.

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: 11/02/2024 **Time of Death:** 04:45 AM

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

County where fatality incident occurred: Madison

Was 911 or local emergency number called? Yes

Time of Call: 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)

LDSS Response

On 11/2/24, MCDSS received a report regarding the death of the subject child. MCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. MCDSS contacted the source of the report, completed a CPS history review, and informed the DA of the fatality.

MCDSS interviewed the parents who reported the father was home alone with the SC while the mother was out with friends. The father reported he had given the SC a bottle and then the SC fell asleep on the father's chest. The father explained that after the SC fell asleep, he moved the SC to the edge of the couch and cradled the SC in the crook of his arm, positioning the SC facing upwards. The father then fell asleep. The father reported he did not intend to fall asleep but was exhausted. The mother returned home to find the father asleep on the couch. The mother looked for the SC in his bassinet and when she saw the SC was not there, she began to scream "where is the baby". The father woke from his place on the couch and the parents found the SC stuck between the father's body and the couch. The SC was not breathing. The parents administered CPR and contacted 911. EMS arrived and took over CPR for the parents. The SC was transported to the hospital where he was pronounced deceased. The information the parents provided to MCDSS remained consistent with the information they provided to medical staff and law enforcement.

MCDSS coordinated with law enforcement throughout the investigation. Law enforcement noted that upon arrival at the home, the mother appeared to be intoxicated; however, she was not caring for the SC at the time of death. Law enforcement had no concerns for the father being intoxicated.

MCDSS spoke with the SC's primary care provider and hospital staff. Hospital staff reported the SC arrived at the hospital around 4:28PM via EMS. Life-saving measures were administered to no avail and the SC never regained a pulse. Hospital records indicated the "final diagnostic impression" was cardiac arrest. At the hospital, the parents presented as devastated

and did not demonstrate any concerning behaviors. The SC did not appear to have any marks, bruises or abnormalities. The primary care provider had seen the SC three times since his birth and had no concerns for his care. The primary care provider reported discussing safe sleep protocol with the mother; however, had never met with the father.

MCDSS spoke with a service provider who was working with the mother during and after her pregnancy. The caseworker reported that the mother had disclosed concerns for the father's alcohol misuse. The mother had many conversations with the father about his drinking; however, the father was not changing his behavior, and it was discouraging to the mother. The caseworker provided the mother with in-depth training on safe sleep protocol; however, she had not met with the father and was unsure of his knowledge of safe sleep protocol.

MCDSS spoke with the maternal grandmother, paternal grandmother and paternal step-grandfather. No concerns were reported.

MCDSS completed all safety assessments except for the 30-day Safety Assessment and completed the Risk Assessment. MCDSS interviewed the surviving siblings and assessed both their mother and the subject father's homes to be safe. MCDSS appropriately substantiated the allegations of DOA/Fatality and IG against the subject father; however, there is no documentation that MCDSS discussed this outcome with the father.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Pending

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070470 - Deceased Child, Male, 1 Month(s)	070471 - Father, Male, 36 Year(s)	DOA / Fatality	Substantiated
070470 - Deceased Child, Male, 1 Month(s)	070471 - Father, Male, 36 Year(s)	Inadequate Guardianship	Substantiated
070470 - Deceased Child, Male, 1 Month(s)	070472 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
070470 - Deceased Child, Male, 1 Month(s)	070472 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
070470 - Deceased Child, Male, 1 Month(s)	070471 - Father, Male, 36 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
070470 - Deceased Child, Male, 1 Month(s)	070472 - Mother, Female, 29 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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?				

Explain:
No 30-Day Safety Assessment was completed.

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:
Risk was adequately assessed. The surviving siblings were not in need of services. The parents were provided resources for bereavement counseling and support groups.

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

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 parents were provided with resources for bereavement counseling and support groups. They declined the services. The mother reported she planned to engage in therapy with her pervious mental health counselor.

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? No
Explain:
No services were offered to the surviving siblings. They never met the subject child and were not in need of bereavement services.

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 parents were provided with resources for bereavement counseling and support groups.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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)
10/18/2023	Sibling, Female, 10 Years	Other Adult - SS's BM, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 7 Years	Other Adult - SS's BM, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Other Adult - SS's BM's Paramour, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Other Adult - SS's BM's Paramour, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received on 10/18/23, that alleged on an ongoing basis, the surviving sibling's mother and her paramour would throw items with excessive force, such as shoes, at the then 7yo surviving sibling. As a result, after being struck with the items, the surviving sibling experienced lasting pain.

Report Determination: Unfounded | **Date of Determination:** 12/02/2023

Basis for Determination:
The allegations of IG regarding the surviving siblings against their mother and her paramour were unsubstantiated. The then 10yo surviving sibling denied the adults threw objects at the then 7yo surviving sibling. The then 7yo surviving

sibling reported the adults both threw slippers at him on one occasion. He reported that it happened over a year prior. The adults denied the allegations. The surviving siblings reportedly felt safe in the home.

OCFS Review Results:
MCDSS began their investigation within 24 hours, completed a CPS history review, and contacted the source of the report. All family members were interviewed, and the mother's home was assessed to be safe. All safety and risk assessments were completed timely and accurately, and there were detailed progress notes. The SF agreed MCDSS could safety assess his home; however, there is no documentation that MCDSS visited the SF's home or followed up with the SF to schedule a visit.

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)
08/09/2023	Sibling, Female, 10 Years	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Female, 10 Years	Father, Male, 35 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 10 Years	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 7 Years	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 7 Years	Father, Male, 35 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 7 Years	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
MCDSS received an SCR report on 9/8/23, that alleged the subject father drank alcohol to impairment while being the caretaker of the surviving siblings. On 08/05/23, the father was drunk while caring for the SSs and left them alone in a camper while he went to a party. The SSs were not mature enough to be left alone for extended periods of time. When the father drank, he would become physically aggressive in front of the SSs. While in the father's care the SSs were going without food and were hungry. There was an active court order that stated the father was not able to consume alcohol while caring for the SSs.

Report Determination: Indicated | **Date of Determination:** 10/06/2023

Basis for Determination:
MCDSS appropriately substantiated the allegations of IG, PD/AM, and LS against the subject father regarding the surviving siblings. The SS's mother was contacted by a friend to pick the SSs up at a campground because the SF was intoxicated. The SSs reported the SF had been drinking alcohol and was intoxicated. They reported he drank alcohol every weekend they were with him. The then 10yo SS reported the SF attempted to drive them home; however, was stopped by a friend. The SF became angry and punched a couple of cars. The SF admitted he had been drinking alcohol. The allegations of IF/C/S against the SF regarding the SSs were appropriately unsubstantiated.

OCFS Review Results:
MCDSS began their investigation within 24 hours, completed a CPS history review, and contacted the source. The SF resided in Chenango County and Chenango County Department of Social Services (CCDSS) visited his home. All family members were interviewed, and the SSs and their homes were assessed to be safe. All safety and risk assessments were completed timely and accurately, and there were detailed progress notes documented. MCDSS did not attempt to contact

the SF's probation officer for updated information. MCDSS did not document discussing the substantiation of allegations with SF.

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)
07/19/2022	Sibling, Female, 9 Years	Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Sibling, Female, 9 Years	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Years	Father, Male, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 9 Years	Father, Male, 33 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
An SCR report was received on 7/19/22, that alleged on 7/14/22, the SF was intoxicated and irate, punched holes in the wall, and was too impaired to care for the SSs. A subsequent report was received on 7/26/22, that alleged the SSs visited the SF's home every other weekend and were not allowed to bathe, change their clothing including underwear, or brush their teeth while there. Additionally, the SF was refusing to provide the then 9yo SS with an eye patch she needed to wear to strengthen her eye.

Report Determination: Unfounded | **Date of Determination:** 09/08/2022

Basis for Determination:
MCDSS appropriately unsubstantiated the allegations of IG, PD/AM, and IF/C/S against the SF regarding the SSs and LMC against the SF regarding the then 9yo SS. The subsequent report listed the SF's girlfriend and her children as residing in the home and listed the girlfriend as a subject. MCDSS determined the BF's girlfriend and her children did not reside in the home and the girlfriend was not a person legally responsible for the SSs. She and her children were removed from the case.

OCFS Review Results:
MCDSS began their investigation within 24 hours, completed a CPS history review, and contacted the source of both reports. The SF resided in Chenango County and CCDSS visited his home. All family members were interviewed, and the children and their homes were assessed to be safe. All safety and risk assessments were completed timely and accurately, relevant collaterals were contacted, and there were detailed progress notes documenting all comprehensive interviews and exhibiting best casework practice.

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

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

A CPS investigation was opened from 6/21/21 through 7/23/21. The allegations of IG were unsubstantiated against the

SS's mother and her paramour regarding both SSs.

A CPS investigation was opened from 4/15/13 through 7/10/13. The allegations of IG and IF/C/S were substantiated against the SF regarding the then 23-day-old SS and another child.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐Family Court ☒Criminal Court ☒Order of Protection

Criminal Charge: Other - Criminal Mischief **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Subject Father	Unknown	Unknown
Comments:	The subject father was charged with criminal mischief due to damaging the vehicle of the paramour to the surviving sibling's mother. It was unknown when this incident occurred. As a result of the charge, the father was on probation.		

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: In the July 2022 CPS investigation, it was determined that the subject father had an order of protection in place against him in favor of the surviving sibling's mother and her paramour. It was unclear when the order was issued.	

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