Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-25-027

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

Issue Date: Nov 05, 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 Grandmother	MGF-Maternal Grandfather	FF-Foster Father
PGM-Paternal Grandmother	PGF-Paternal Grandfather	DCP-Day Care Provider
MGGM-Maternal Great Grandmother	MGGF-Maternal Great Grandfather	PGGF-Paternal Great Grandfather
PGGM-Paternal Great Grandmother	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-Caseworker	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: 22 day(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 06/08/2025
Initial Date OCFS Notified: 06/08/2025

Presenting Information

An SCR report was received that alleged in the morning on 6/8/25, at approximately 8:15AM, the subject mother put the 22-day-old subject child to sleep after feeding him. The 4-year-old surviving sibling was sleeping on the outside of the bed, the subject child was sleeping in the middle of the bed, and the mother was sleeping on the inside of the bed against the wall. The subject mother woke at approximately 10:15AM, to feed the subject child and noticed that he was blue and bleeding from his mouth. The mother attempted cardiopulmonary resuscitation (CPR) and called 911. Emergency services arrived and the subject child was taken to the hospital where he was pronounced deceased at 10:59AM. It was believed that the unsafe sleep conditions contributed to the death.

Executive Summary

This report concerns the death of a 22-day-old male child that occurred on 6/8/25. Oneida County Department of Family and Community Services (OCDFCS) received an SCR report on that same date regarding the fatality. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the subject mother. There was an open CPS investigation at the time of the death that initiated on 5/13/25. The concerns surrounding the open investigation were a result of the mother testing positive for cocaine at the time of the subject child's birth.

At the time of his death, the subject child resided with his mother, father and surviving siblings ages 4 and 1 years old. OCDFCS immediately initiated their investigation and implemented a safety plan requiring the parents and children stay with the maternal grandparents, and the parents were not to use any drugs that were not prescribed to them. The safety plan was later modified, requiring the parents have only supervised contact with their children, reside at the maternal grandmother's home and not use any drugs that were not prescribed to them. The change in the safety plan resulted from the parent's noncompliance with completing drugs screens.

Through a joint investigation with law enforcement, it was learned on 6/8/25, the subject child was found deceased by the subject mother in his bassinet. The mother yelled for the father who contacted 911 and the mother initiated CPR Emergency medical services and law enforcement responded to the home and continued life-saving efforts. The subject child was transported to the hospital where life-saving efforts continued; however, were unsuccessful. The subject child was pronounced deceased on 6/8/25 at 10:59AM.

OCDFCS communicated with the medical examiner's office regarding the final autopsy report, which was still pending. OCDFCS communicated with law enforcement and the district attorney's office and learned the criminal investigation was still open awaiting the final autopsy report. At the time this report had been written, there were no pending criminal charges against the parents.

The investigation remained open and had not yet been determined as OCDFCS was awaiting the final autopsy report. The 24-Hour and 30-Day Fatality reports were completed timely. Safety Assessments that were completed were done timely and with accuracy. OCDFCS gathered information from collateral contacts such as law enforcement, the district attorney's office, EMS, hospital staff, district agency staff and the family. Efforts were made to obtain information from the parent's substance abuse providers; however, to date have been unsuccessful. Required notifications were provided to

the parents and progress notes were entered contemporaneously. Information regarding bereavement services and burial assistance were provided to the parents.

PIP Requirement

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Unable to Determine
- **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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:

At the time this report was written, the investigation remained open and had not yet been determined. OCDFCS documented they were awaiting the findings of the final autopsy report.

Was the decision to close the case appropriate? N/A

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: 06/08/2025 **Time of Death:** 10:59 AM

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

County where fatality incident occurred: Oneida
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	22 Day(s)
Deceased Child's Household	Father	No Role	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)

LDSS Response

On 6/8/25, OCDFCS received an SCR report regarding the death of the SC which occurred on that same date. OCDFCS initiated their investigation within 24 hours, notified the DA, and coordinated their efforts with LE. OCDFCS contacted the source of the report and completed a CPS history check.

OCDFCS completed an interview with the BF at the MGM's residence. During his interview, he explained that he does not share a bedroom with the mother and sleeps in his own room. The BF reported the 1yo SS was sleeping in her crib that was in the SM's room. The SM and 4yo SS both shared a sleep surface (SM's bed) with the SC, who was placed in a "hard" bassinet in the middle of the bed between the SM and SS. The BF woke around 10:00AM to the SM screaming. The BF ran into the bedroom and observed the SC to be blue and the SM was attempting resuscitative efforts. The BF reported the SC was swaddled in a blanket, he denied there was anything else in the bassinet with the SC. The BF confirmed the SM used drugs during her pregnancy; however, he was unaware at the time she was using. The BF learned of the drug concerns when the SM tested positive at delivery. The BF also confirmed the SM suffered from a MH condition throughout her pregnancy.

OCDFCS completed an interview with the SM at the MGM's residence. During her interview, she explained between 7:00-8:00AM she woke and fed the SC, changed his diaper and then placed him back into his bassinet. The SM described the bassinet as "hard bottom/sided bassinet." The SM placed the bassinet in the middle of the bed while she and the 4yo SS were both on either side. The SM explained she swaddled the SC in a blanket and denied anything else being in the bassinet with the SC. The SM reported she woke around 10:00AM, observed the SS sitting up next to the bassinet, and when the SM looked into the bassinet, she observed the SC's cheek to be blue. The SM immediately grabbed the SC and removed his swaddle and clothing to observe the SC's skin; the SM noted the skin color was not a normal color and the SC still felt warm. The SM reported that she recalled hitting the SC's back thinking he may have chocked on spit up. The SM then tried to breathe into the SC's mouth and nose, which was unsuccessful, so she started screaming. The BF then ran into the room and called 911, while the SM ran to the MGM's home for help. The SM and MGM returned and attempted CPR until first responders arrived and transported the SC to the hospital. The SM reported the SC had congestion "on and off" prior to the death, but not the day of the fatality. The SM explained during her pregnancy she had a MH condition, did not receive prenatal care, and admitted to using cocaine.

OCDFCS communicated with the staff from the ME's office who responded to the home with LE to observe the scene and complete a doll reenactment. Information gathered was received prior to the autopsy being performed. There were no immediate concerns noted at the residence. It was reported that the bassinet was "small" and was appropriate for the SC. The SC was found to have a clavicle fracture, which was noted to be healing and could have been as recent as "5-7 days old," and there was a likelihood the injury could have been sustained during delivery. It was noted there were no "obvious signs of abuse or that someone inflicted the injury." There was blood observed in the mouth and nose, but no evidence of injury found. Due to the clavicle fracture, LE "labeled the death suspicious."

Multiple home visits were completed with the family; they continued to abide by the safety plan and still resided with the MGM. The SM was asked to complete a substance abuse evaluation, which she reported doing and was not recommended treatment. Multiple attempts were made to obtain information regarding her evaluation; however, had not been received at the time of this writing. The investigation remained open and had still not yet been determined.

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

Comments: Oneida County referred this case to their local Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
072588 - Deceased Child, Male, 22 Day(s)	072589 - Mother, Female, 36 Year(s)	DOA / Fatality	Pending
072588 - Deceased Child, Male, 22 Day(s)	072589 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐

At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☐	☒	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☐	☐	☐	☒
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☐	☐	☐	☒

Placement Activities in Response to the Fatality Investigation

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

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 SM was referred for a substance abuse evaluation and MH. The BF reported already being engaged in substance abuse counseling. OCDFCS made multiple attempts to obtain information regarding the SM and BF's compliance with treatment; however, to date have been unsuccessful.

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:
The family was offered fatality related 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 subject mother and father were provided with information regarding bereavement services and burial assistance.

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

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)
05/19/2025	Deceased Child, Male, 1 Days	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 1 Days	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report was received that alleged on 5/17/25, the subject mother gave birth to the subject child. The subject mother's toxicology was positive for cocaine at the time of delivery. The subject child's toxicology was pending.

Report Determination: Unfounded

Date of Determination: 07/28/2025

Basis for Determination:
OCDFCS unsubstantiated the allegations of Inadequate Guardianship and Parent's Drug/Alcohol Misuse against the subject mother regarding the subject child. The investigation revealed the subject mother admitted to using cocaine throughout her pregnancy due to having a mental health condition. Attempts were made to drug screen the subject child; however, were unsuccessful. Safe sleep and a plan of safe care were reviewed with the parents. The mother was referred to community-based services; however, contact with the mother was unsuccessful and her referral was closed. The subject child died during this investigation on 6/8/25, further concerns were addressed in the fatality investigation.

OCFS Review Results:
OCDFCS immediately initiated their investigation, spoke to the source of the report and completed a CPS history review.

Interviews were completed with the mother and father. OCDFCS completed a home visit, observed sleeping conditions, reviewed safe sleep and completed a plan of safe care with the family. The mother was referred to mental health and substance abuse services; however, her participation with completing an evaluation was still unknown at the time of case closure. Required notices were provided to the parents. The family continued to be monitored through the open fatality investigation.

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)
05/30/2023	Sibling, Female, 3 Days	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 3 Days	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report was received that alleged the subject mother gave birth to the then 3-day-old surviving sibling on 5/27/23. Both the subject mother and surviving sibling had tested positive for cocaine at delivery. The subject mother had no plan of safe care in place.

Report Determination: Unfounded | **Date of Determination:** 06/13/2024

Basis for Determination:
The mother admitted to cocaine use due to a mental health condition. The mother engaged in treatment and was compliant. The father was also in treatment and was reported to be initially compliant. There was no effect on the child. The surviving siblings were up to date medically and there were no concerns.

OCFS Review Results:
Due to the concerns regarding substance use for both parents and two young children residing in the home it remained unclear why there was no casework activity from 8/29/23-5/14/24 (8 months and 17 days). There were only 3 home visits completed during the investigation that was open for 12 months and 14 days. There was supervisory directive to address the father's positive drug screens in 2023; however, the concerns were never addressed. A plan of safe care was completed by the hospital. Safe sleep provisions were observed, and education was provided. The 7-day safety assessment was not accurate as safety factor #15 should have been selected as the child had a positive toxicology.

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

Issue:

Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:

There was a supervisory directive on 8/28/23 to discuss the father's positive drug screens and both the mother and father's compliance with treatment. The father's drugs screens were never discussed and attempts to engage the family were not completed until 5/15/24 (8 months later).

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(c)

Action:

OCDFCS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

OCDFCS had no contact with the family from 6/21/23 to 5/14/24, and there was no casework activity from 8/29/23 to 5/14/24.

Legal Reference:

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

Action:

OCDFCS must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

Issue:

Timely/Adequate Seven Day Assessment

Summary:

Safety factor #15 should have been selected as the then 3-day-old surviving sibling had a positive toxicology for cocaine at birth.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

OCDFCS will document and approve all assessments and accurately reflect the safety factors that are present.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The subject mother reported being depressed during her pregnancy, which was not accurately reflected in the Risk Assessment Profile.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

[redacted]

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

On 3/11/21, OCDFCS received an SCR report with concerns for the subject mother and now 4-year-old surviving sibling both having a positive toxicology for cocaine and marijuana at the time of surviving sibling's birth. The allegation of Parent's Drug Alcohol Misuse was unsubstantiated against the mother. The parents engaged in substance abuse treatment and were offered preventive services. The parent's accepted preventive services where they would continue to be monitored and the investigation was closed on 10/21/21.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

5/5/21-10/27/22 OCDFCS opened a Preventive Services Case for the subject mother, subject father and now 4-year-old surviving sibling due to concerns for substance abuse issues and mental health conditions. The services case was opened as a result of a CPS investigation where the mother had a positive toxicology at the birth of the now 4-year-old surviving sibling. The parents initially worked with service providers and requested their case be closed. There was no casework activity or casework contacts after 10/25/21. From the date of 10/25/21, the case remained open for 12 months and 2 days and was eventually closed on 10/27/22, with no supervisory note or recent contact with the family.

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