Child Fatality Report

Report Identification Number: SY-17-012

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

Issue Date: Aug 22, 2017

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

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children		
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
CPR-Cardiopulmonary Resuscitation		
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	
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

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 05/18/2011
Initial Date OCFS Notified: 04/10/2017

Presenting Information

SCR report alleged the infant SC previously died due to neglect while in the care of the SM; details were unknown. The report further alleged the following present-day concerns: the SM and a male parent substitute (PS) were abusing drugs and alcohol, and would leave 5 children (ages 7 through under 1) unsupervised daily while impaired. The SM sold food stamps to purchase drugs and alcohol, resulting in no food in the home and missed meals for the children. There were inadequate sleeping arrangements for the children. The PS hit them on an ongoing basis, once resulting in an injury to the 3-year-old. The SM was aware of the PS' inappropriate treatment of the children but failed to intervene. Another mother (allegedly the mother to the 7 and 1-year-old children) was aware of all the concerns but failed to intervene or make alternate plans for her children. The BF to all the surviving children, allegedly in jail at the time, had an unknown role.

Executive Summary

An SCR report was received by Onondaga County Department of Children and Family Services (OCDCFS) on 4/8/2017 concerning the death of the male SC. It was alleged the SM's neglect was the cause of the SC's death. The SC was 4 months old at the time of his death, and died on 5/18/2011. A previous SCR report had been made at that time, and the Multi-Disciplinary Team investigated the fatality.

OCDCFS immediately reviewed the previous Child Protective Service (CPS) investigation and discovered the ME had declared the cause of the SC's death to be Sudden Infant Death Syndrome (SIDS). OCDCFS determined from their review that LE need not be part of this investigation, as LE had previously found no criminal nature with respect to the fatality, and no new information about the death was presented.

The SM, who was the only caregiver for the SC at his time of death, had been found not to be responsible for the SC's death. On 5/17/2011, the SC had been placed to sleep for the night by SM on his back, in a bassinet, with nothing inside of it. The bassinet was placed on top of the SM's bed, where that evening she slept in between the SC's bassinet and the SS, who was 2 years old at the time. The SM awoke in the morning to find the SC in the same position, but unresponsive. 911 was called, but the SC was unable to be revived.

In addition to the now 8-year-old SS, there was one additional SS born after the fatality, currently 2 years old. There were no safety concerns revealed for either SS. OCDCFS also found no concerns for the other children who were named in the report, ages 4, 3, and 1, who resided in a different household with their mother. The SC and both SS each had a different BF. One SS shared a BF in common with 2 children in the other household. OCDCFS notified all 3 fathers of the surviving children, who were all incarcerated at the time of this investigation. OCDCFS documented previous conversations with the SC's BF from the 2011 investigation.

OCDCFS pulled forward all pertinent information from the previous investigation, investigated newly reported concerns alleged against SM and the other mother, and discussed the SC's death again with the SM who was the only adult present on the date of the fatality.

The case record reflected no new information that would lead to a determination different than that of "unfounded" which was made in 2011. There were no current safety concerns for any child listed on the current case. At the time of the

writing of this report, the CPS investigation had not yet been closed. SM had been offered services in 2011. The SM and SS appeared to have no present service needs.

For this investigation, OCDCFS was cited for timeliness of the 24-hour safety assessment and failure to complete the 7-day safety assessment. In addition, there were citations in the review of the historical case. In response, OCDCFS will submit a PIP to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) OCDCFS has taken, or will take, to address the cited issues. For citations where a PIP is currently implemented, OCDCFS will review the plan(s) and revise as needed to further 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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
No determination has been made at this time. Though in the first 24 hours there were unresolved concerns for the children named in the report due to inability to make contact, the initial safety assessment reflected no safety factors; however, as it pertained to facts known about the fatality and the children's safety, the appropriate safety decision was recorded.

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:
The case remains open at the time of the writing of this report.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-hour safety assessment was not approved until four days past the due date.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	A safety assessment will be completed and approved by a supervisor within 24 hours of a report if such report contains the allegation of DOA/Fatality, as required.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	There was no 7-day safety assessment completed in Connections for this investigation.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-day safety assessment in Connections.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/18/2011 **Time of Death:** 07:00 AM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 7 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	4 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	8 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Other Household 1	Other Adult - BM of Other Children	Alleged Perpetrator	Female	21 Year(s)
Other Household 1	Other Child - Unrelated Child	Alleged Victim	Female	4 Year(s)
Other Household 1	Other Child - Unrelated Child	Alleged Victim	Male	3 Year(s)
Other Household 1	Other Child - Unrelated Child	Alleged Victim	Male	1 Year(s)
Other Household 2	Other Adult - BF of 2-year-old SS and 3- & 4-year-old OC	No Role	Male	32 Year(s)
Other Household 3	Other Adult - BF of 8-year-old SS	No Role	Male	25 Year(s)
Other Household 4	Other Adult - BF of 1-year-old Unrelated Child	No Role	Male	26 Year(s)

LDSS Response

On 4/8/2017, OCDCFS received an SCR report with allegations concerning the death of the SC, who died at 4 months of age in 2011, and verified the death had previously been investigated by LE and CPS in 2011. Similar to the 2011 report of the death, SM was the only subject concerning the SC. On the new report, another mother (unrelated to the SC) was listed in addition to her children. There were new allegations regarding both mothers and their children, some of whom shared a common biological father. OCDCFS determined the two mothers and their children resided in separate households.

Within 24 hours of the new report, OCDCFS reviewed the previous fatality investigation, contacted the source, and attempted face-to-face contact with the mothers and children. Contact with the family members was not successful until three days later despite the Department's diligent efforts.

It was determined the alleged PS was reported in error as the mothers reported not knowing anyone who could fit that description. SM's child also denied any adult male frequenting the home or caring for them. OCDCFS addressed the reported present-day concerns by way of familial and collateral contacts and documented that there was no credible evidence to substantiate those allegations.

From their review of the 2011 investigation, OCDCFS determined that the ME previously concluded the cause of the SC's death to be SIDS. For that investigation, OCDCFS had unfounded the allegations against SM regarding the SC's death, due to the ME's declaration of the cause of death. It was learned the SM had lived alone with the SC and the SS, who was 2 years old at the time. SM had placed the SC to sleep for the night on his back in a bassinet with nothing inside of it. The bassinet was placed on top of the SM's bed where she slept with the SS. The SM awoke in the morning to find the SC in

the same position, but unresponsive. SM called the PA in a panic requesting assistance, fearing that a call to 911 would take too long. The PA contacted 911 and when EMS responded, they were unable to revive the SC.

The SC had been prescribed nasal spray by the pediatrician to treat congestion two weeks prior to his death, but he had no known debilitating medical illnesses or conditions. The SM reported the SC was not given nasal spray or any other medications or remedies the night preceding his death.

The BF was incarcerated at the time of the SC's death, but was released while that investigation was open. At that time, OCDCFS interviewed him, as well as other relatives and pertinent collateral contacts and found there to be no concerns for the SC's care. OCDCFS discussed the SC's death again with SM during the current investigation. Since the BF had no role in the death six years ago nor did he have any other children with the SM, it was not necessary for him to be contacted for this investigation.

Although neither investigation noted whether a safe sleep discussion was held with SM, SM did share her regular sleep practices with the SC during the previous investigation. The regular practice SM used was placing the SC in his own bassinet on his back with no blankets, pillows, or other items. Such practices are indicative of today's safe sleep standards currently recommended by OCFS.

OCDCFS adequately investigated the current concerns as well as recorded information regarding the previous fatality investigation, though there were safety assessments that were late and/or missing. The case had not yet been determined or closed at the time of the writing of this report, though from review it appeared there was sufficient information gathered to determine all allegations.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? No
Comments: OCDCFS MDT Unit investigated this report but determined a multi-disciplinary approach was not necessary as it was previously investigated jointly in 2011. At that time, LE had no need to press charges related to the death as the cause of death was non-criminal in nature.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Although there is an OCFS approved Child Fatality Review Team in Onondaga County, this fatality was not reviewed during this investigation. The Onondaga CFRT did review this case when it was initially reported in 2011.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039761 - Deceased Child, Male, 4 Mons	039763 - Mother, Female, 26 Year(s)	DOA / Fatality	Pending
039761 - Deceased Child, Male, 4 Mons	039763 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending

039764 - Sibling, Female, 8 Year(s)	039763 - Mother, Female, 26 Year(s)	Lack of Supervision	Pending
039764 - Sibling, Female, 8 Year(s)	039763 - Mother, Female, 26 Year(s)	Parents Drug / Alcohol Misuse	Pending
039764 - Sibling, Female, 8 Year(s)	039763 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
039764 - Sibling, Female, 8 Year(s)	039763 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Pending
039764 - Sibling, Female, 8 Year(s)	039766 - Other Adult - BM of Other Children, Female, 21 Year(s)	Inadequate Guardianship	Pending
039765 - Sibling, Male, 2 Year(s)	039763 - Mother, Female, 26 Year(s)	Lack of Supervision	Pending
039765 - Sibling, Male, 2 Year(s)	039763 - Mother, Female, 26 Year(s)	Parents Drug / Alcohol Misuse	Pending
039765 - Sibling, Male, 2 Year(s)	039763 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
039765 - Sibling, Male, 2 Year(s)	039763 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Pending
039770 - Other Child - Unrelated Child, Male, 1 Year(s)	039763 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Pending
039770 - Other Child - Unrelated Child, Male, 1 Year(s)	039763 - Mother, Female, 26 Year(s)	Parents Drug / Alcohol Misuse	Pending
039770 - Other Child - Unrelated Child, Male, 1 Year(s)	039766 - Other Adult - BM of Other Children, Female, 21 Year(s)	Inadequate Guardianship	Pending
039770 - Other Child - Unrelated Child, Male, 1 Year(s)	039763 - Mother, Female, 26 Year(s)	Lack of Supervision	Pending
039770 - Other Child - Unrelated Child, Male, 1 Year(s)	039763 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
039771 - Other Child - Unrelated Child, Male, 3 Year(s)	039763 - Mother, Female, 26 Year(s)	Lack of Supervision	Pending
039771 - Other Child - Unrelated Child, Male, 3 Year(s)	039763 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Pending
039771 - Other Child - Unrelated Child, Male, 3 Year(s)	039763 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
039771 - Other Child - Unrelated Child, Male, 3 Year(s)	039763 - Mother, Female, 26 Year(s)	Parents Drug / Alcohol Misuse	Pending
039772 - Other Child - Unrelated Child, Female, 4 Year(s)	039763 - Mother, Female, 26 Year(s)	Lack of Supervision	Pending
039772 - Other Child - Unrelated Child, Female, 4 Year(s)	039763 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Pending
039772 - Other Child - Unrelated Child, Female, 4 Year(s)	039763 - Mother, Female, 26 Year(s)	Parents Drug / Alcohol Misuse	Pending
039772 - Other Child - Unrelated Child, Female, 4 Year(s)	039763 - Mother, Female, 26 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?	☐	☐	☒	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
Of the 3 incarcerated BFs on the report, a letter was sent to 1 of them requesting phone contact. The other 2 were sent notification letters. Safety assessments were late/missing.

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 safety 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: The children were seen and assessed for safety by day 7; however, the safety assessment document was never completed				

in Connections.

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:
A RAP was not yet completed at the time of the writing of this report, as the case had not yet been closed.

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
There was no removal necessary regarding any of the surviving children at any point during the investigation.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☐	☐	☐	☒	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐

Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
No service needs were identified during this investigation. Services regarding the fatality were offered during the first investigation, at the time in which the fatality occurred six years ago.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
No services were provided as no immediate needs presented due to the length of time since the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
No services were provided as no immediate needs presented due to the length of time since the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/10/2016	Sibling, Male, 1 Years	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unfounded	Yes
	Sibling, Female, 7 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 7 Years	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 1 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	

Report Summary:
SCR report alleged SM used an illicit psychoactive drug to the point of impairment while caring for the two SS, ages 1 and 7. As a result, the SM would become too impaired to provide adequate care to the children thus placing them at risk. The BF of the 1-year-old SS had no role.

Determination: Unfounded | **Date of Determination:** 06/21/2016

Basis for Determination:
OCDCFS spoke with the 7-year-old SS who made no concerning disclosures, as well as the SM who denied the allegations. OCDCFS determined there was no credible evidence to substantiate the allegations based on observations and interviews with collateral and familial contacts.

OCFS Review Results:
OCDCFS gathered an adequate amount of information upon which to base the determination. OCDCFS completed the 7-day safety assessment 16 days late. There was no effort to interview either BF, who were both listed on the report. OCDCFS had information that both were incarcerated but there was no effort documented to attempt to speak with them about the report concerning their children.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
OCDCFS completed the 7-day safety assessment 16 days late.

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

Action:
OCDCFS will complete all safety assessments in the amount of time required.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
There was no effort to interview either BF, who were both listed on the report. OCDCFS had information that both were incarcerated but there was no effort documented to attempt to speak with them about the report concerning their children.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
OCDCFS will make diligent efforts to interview all parents of children named in a report.

[redacted]

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

There is no CPS investigative history more than three years prior to the fatality.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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