Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-22-026

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

Issue Date: Nov 17, 2022

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	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: 11 year(s)
Jurisdiction: Oswego
Gender: Male
Date of Death: 07/20/2020
Initial Date OCFS Notified: 05/22/2022

Presenting Information

An SCR report was received which alleged that in January 2020, the eleven-year-old subject child was diagnosed with type 1 diabetes and hospitalized with diabetic ketoacidosis. The child returned home in February 2020. From February 2020 until July 2020, the child was having breathing issues related to asthma. The mother and parent substitute failed to seek any medical assistance during that time. On 7/20/20, the subject child had an asthma attack and stopped breathing. He was transported to the hospital via ambulance but could not be revived.

Executive Summary

This fatality report concerns the death of an eleven-year-old male subject child that occurred on 7/20/20. A report was registered with the SCR on 5/23/22 with allegations of Inadequate Guardianship, Lack of Medical Care, and DOA/Fatality against the child's mother and parent substitute. Oswego County Department of Social Services (OCDSS) received the report and investigated the child's death. An autopsy was not completed, and the record did not reflect an official cause and manner of death.

At the time of the child's death, he resided with his mother, parent substitute, and four surviving siblings, ages sixteen years old (SS1), fourteen years old (SS2), one year old (SS3) and two months old (SS4). The parent substitute was the biological father of the youngest sibling and had recently moved out of the home. The eldest sibling's biological father was incarcerated, and the biological father of the other children had been deceased since 2020. The investigation revealed that the subject child had been recently diagnosed with type 1 juvenile diabetes and was also suffering from a form of asthma that was difficult to control. Through interviews and medical records, it was found that on 7/19/20 while at home with his mother, parent substitute and siblings, the subject child was in the kitchen washing dishes when he suddenly became short of breath and collapsed. The eldest sibling called emergency services while the parent substitute began cardiopulmonary resuscitation. The child was transported via ambulance to the hospital where he was pronounced deceased. The record did not reflect the official time or date of death via medical documentation; however, the mother reported the date of death as 7/20/20.

At the time the fatality investigation was received, the family was involved in an ongoing CPS investigation with allegations unrelated to the subject child's death, which was initiated on 5/18/22 due to concerns the mother was misusing drugs and physically abusing the surviving siblings. Although those concerns were thoroughly investigated by OCDSS, the allegations specific to the fatality were not fully explored. Collateral sources who may have had pertinent information related to the incident and the subject child's health were not contacted. The eldest surviving siblings were not interviewed surrounding the subject child's death, nor was the parent substitute, who was named as a subject and resided in the home at the time the fatality occurred. Due to the current substance misuse concerns, family court intervention was sought, and a court ordered services case was opened. There were no documented criminal charges related to the subject child's death. The fatality investigation had not yet been determined at the time this report was issued. Family court proceedings remained ongoing at the time of this writing, and the surviving siblings were deemed safe.

PIP Requirement

This review resulted in citations related to casework practice. In response, OCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS will review the plan(s) and revise as needed.

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?** 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?** Unable to Determine

Explain:
The record did not reflect if the circumstances surrounding the subject child's death were fully explored. The investigation had not yet been determined at the time of this writing.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The allegations regarding the fatality were not fully explored by OCDSS.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect if collateral contacts were spoken with specific to the fatality, including LE, ER staff, SC's doctors, first responders, and SC's school. These individuals may have had information pertinent to the allegations.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:	The record did not reflect if SS1, SS2 or PS were interviewed regarding the fatality.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	OCDSS will make efforts to make casework contacts with biological parents and/or other persons named in a report. Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/20/2020 **Time of Death:** Unknown

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

County where fatality incident occurred: Oswego
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 alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Washing dishes.

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	11 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	14 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Sibling	No Role	Female	16 Year(s)

LDSS Response

On 5/22/22, OCDSS met with SM at her home. SM explained that when SC was 10yo, he was overweight and began trying to lose weight so he could play football at school. She stated he would drink a lot of water and lost about 30 pounds within 3 months. She stated he then began getting sick frequently, with strep throat and a rash. She said by winter of 2018, SC was still losing weight, drinking a lot of water, and started wetting the bed. SM stated in December of 2019, SM took SC to urgent care, and he tested positive for the flu. She said they were sent home and told to give him fluids and medications. SM reported that over the next few days, SC's speech was slurred, and he began hallucinating. She said they took SC to the hospital again, and he was in extreme diabetic ketoacidosis. She reported they had to intubate him, and he was admitted for 9 days. SM explained he was diagnosed with type 1 diabetes, and she learned how to administer his insulin. SM reported SC was also being followed by a pulmonologist, as he struggled with asthma and had begun spitting up blood. SM explained they brought him to the pulmonologist a few days before his death, and he was sent to the hospital for x-rays and new medications were started. SM reported that on 7/19/20, SC was acting better. She stated she went in the back room of the home to breastfeed SS and then began to hear screaming from SS1 and SS2. SM said she found SC struggling to breathe and collapsed. SM had SS1 call 911 while PS began CPR. SM stated by the time they got to the hospital she knew SC had died. The home was observed to meet minimal standards and the 2 youngest SSs were deemed safe at this visit.

On 5/23/22, OCDSS met with SS2 at her residence, where she lived with SS1, who was now an adult, and SS1's boyfriend. SS2 was briefly interviewed and explained she felt PS was administering CPR incorrectly to SC when SC became unresponsive and that is what caused his death. OCDSS did not interview SS2 further and noted that CAC interviews would occur with LE so that more information could be gathered. SS2 reported fear of PS and corroborated the allegations against PS that were unrelated to the fatality. SS2 reported no safety concerns at her current home and was deemed safe at this visit.

OCDSS obtained medical records from hospitals and an urgent care regarding SC. It was noted that SC was seen several times for medical concerns in the months leading up to his death, including 2 hospitalizations which involved intubation. It was also documented that SC was followed regularly by a pulmonologist and there were several appointments with doctors addressing his diabetes. It was noted SC was prescribed numerous medications to manage his diabetes and asthma and was to be followed closely by an ENT specialist, speech therapist, a pediatric endocrinologist, his primary care provider, and pulmonologist. It was also noted that SC did not show for his initial ENT appointment scheduled in March 2020. The record did not reflect if OCDSS contacted any of SC's providers to inquire about SC's care or if SM was following all treatment recommendations.

During this investigation, concerns surrounding SM and ongoing drug misuse led to the removal of her 3 CHN and family court intervention. Although SS1 and SS2 were interviewed, the record did not reflect if OCDSS addressed the allegations surrounding the fatality. The record also did not reflect if other relevant collateral sources were contacted regarding SC's death, including SC's school, LE, first responders, ER staff, and PS, who was named as a subject on the report. A court ordered services case was opened in response to the additional allegations unrelated to the fatality. The fatality investigation had not yet been determined at the time of this writing, and the services case remained ongoing.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: This fatality investigation was conducted by the Oswego County MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: The fatality was submitted for review by the Oswego County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061981 - Deceased Child, Male, 11 Yrs	061982 - Mother, Female, 33 Year(s)	DOA / Fatality	Pending
061981 - Deceased Child, Male, 11 Yrs	061982 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
061981 - Deceased Child, Male, 11 Yrs	061982 - Mother, Female, 33 Year(s)	Lack of Medical Care	Pending
061981 - Deceased Child, Male, 11 Yrs	061983 - Mother's Partner, Male, 32 Year(s)	DOA / Fatality	Pending
061981 - Deceased Child, Male, 11 Yrs	061983 - Mother's Partner, Male, 32 Year(s)	Inadequate Guardianship	Pending
061981 - Deceased Child, Male, 11 Yrs	061983 - Mother's Partner, Male, 32 Year(s)	Lack of Medical Care	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Law Enforcement	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☒	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The record did not reflect if all pertinent collaterals were interviewed regarding the fatality. The parent substitute was also not interviewed. Progress notes and other required documentation were entered timely.

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: A court ordered services case was opened in response to the concerns unrelated to the fatality and mental health services were offered to the SM, PS and the SSs.				

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: The surviving siblings were removed from the care of SM and PS for reasons unrelated to the fatality.				

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
08/30/2022	There was not a fact finding	There was not a disposition
Respondent:	061982 Mother Female 33 Year(s)	
Comments:	The surviving siblings were removed and a neglect petition was filed after the mother was found to be impaired and acting erratically while caring for the children. Drugs and drug paraphernalia were also found in the home.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Court Ordered Services

Additional information, if necessary:
The record did not reflect if bereavement services were offered to the family; however, a court ordered services case was opened in response to concerns unrelated to the subject child's death, which included mental health counseling referrals. The record did not reflect if family planning services were offered. Funeral assistance services were not needed as SC died in 2020.

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? Yes
Explain:
A court ordered services case was opened following concerns that were found unrelated to the fatality, and mental health services were offered to the family for the SSs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
A court ordered services case was opened following concerns that were found unrelated to the fatality, and mental health services were offered to SM and PS.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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? Yes

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)

05/18/2022	Sibling, Female, 16 Years	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Substantiated	No
	Sibling, Female, 16 Years	Mother, Female, 35 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 16 Years	Mother, Female, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 16 Years	Mother's Partner, Male, 34 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 16 Years	Mother's Partner, Male, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 35 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 35 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 35 Years	Lack of Medical Care	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 35 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 4 Years	Mother's Partner, Male, 34 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 4 Years	Mother's Partner, Male, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 35 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 2 Years	Mother, Female, 35 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 2 Years	Mother, Female, 35 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 35 Years	Lack of Medical Care	Substantiated	
	Sibling, Female, 2 Years	Mother, Female, 35 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 2 Years	Mother, Female, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 35 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 2 Years	Mother's Partner, Male, 34 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that SM had a history of substance misuse, including heroin, while in the

presence of the SSs. SM would get violent with the SSs and inflict bruises on them. SM would also lock the SSs in their rooms for hours at a time, was out of control and unable to properly care for the SSs. A SUB report as also received on 5/18/22 with concerns PS was abusing heroin and hitting SM in the presence of the SSs. The SUB also alleged that one month prior, PS drugged SM for several days, refused to allow her to leave the house, and hit her in front of the SSs. PS was also arrested in the past for withholding the SSs from SM.

Report Determination: Indicated | **Date of Determination:** 09/14/2022

Basis for Determination:
PS was found have moved out of the home in January 2022. Interviews with SS1 and SS2 corroborated the allegations that PS was physically and verbally abusive to SM and to the SSs. There was no evidence gathered to show SM locked the SSs in their rooms or used excessive force when disciplining. SM was found to be impaired during a home visit and needed medical attention. Drugs and drug paraphernalia were also found and were accessible to the SSs. An emergency removal was completed. SS2 was placed in the care of SS1, and the younger SSs were placed with a familial resource. A neglect petition was filed against SM and PS. The case was indicated, and court ordered services were opened.

OCFS Review Results:
This investigation met all statutory requirements.

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)
04/29/2019	Sibling, Female, 13 Years	Mother's Partner, Male, 31 Years	Excessive Corporal Punishment	Unsubstantiated	Yes
	Sibling, Female, 13 Years	Mother's Partner, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 15 Years	Mother, Female, 32 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 15 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 15 Years	Mother, Female, 32 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 15 Years	Mother's Partner, Male, 31 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 15 Years	Mother's Partner, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that on 4/27/19, SM and PS disciplined SS1 by having her wake up early and clean the house. PS made cruel statements to SS1 and carried her to the kitchen sink by the crook of his elbow. SM slapped SS1 across the face, punched her several times and left red marks and scrapes on SS1's cheeks. On 4/28/19, PS put his arm around SS2's neck and carried her to a chair at the dinner table. It was unknown if SS2 sustained any injuries.

Report Determination: Unfounded | **Date of Determination:** 08/12/2019

Basis for Determination:
It was discovered that SS1 was punished after being found at a party. She was expected to complete chores as discipline and her phone was taken away. Although SS1 reported the allegations in the report to be true, the other CHN denied anything physical took place and SS1 was not harmed by SM or PS. SS1 had a scratch under each eye and a bruise under her left eye. Family members reported SS1 told them the family cat scratched her; however, SS1 told CWs the scratches were from the altercation. SC and SS2 denied physical discipline in the home. SS1's school and family members reported concerns that SS1 would sneak out of the home and was using drugs. OCDSS unfounded and closed the case.

OCFS Review Results:
The record did not reflect if services were offered to the family to help address SS1's ongoing behavioral concerns. SS3 was 8 months old at the time of this report; however, the record did not reflect if safe sleep practices were reviewed or if appropriate sleeping provisions were available to the child. Although records were requested from LE on 5/1/19, there was no documented follow up to obtain them. There were no documented attempts to interview the biological fathers of the SSs.

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

Issue:
Failure to provide safe sleep education/information
Summary:
SS2 was 8 months old at the time of this report, and although a brochure regarding safe sleep was provided to SM, the record did not reflect if it was reviewed or if appropriate sleeping provisions were available to the child.
Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1
Action:
OCDSS will provide information on sleep safety to the parents and caretakers of infants whom they encounter, and see that necessary steps are taken to provide safe sleeping conditions for the children in their care.

Issue:
Failure to Offer Appropriate Services
Summary:
The record did not reflect if services were offered to the family to help address SS1's ongoing behavioral concerns.
Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
OCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
Although records were requested from LE on 5/1/19, there was no documented follow up to obtain them.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
There were no documented attempts to interview the biological fathers of the SSs.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
OCDSS will make efforts to make casework contacts with biological parents and/or other persons named in a report. Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/10/2018	Sibling, Female, 14 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 12 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 12 Years	Mother's Partner, Male, 30 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 12 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 12 Years	Mother's Partner, Male, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 14 Years	Mother's Partner, Male, 30 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 14 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 14 Years	Mother's Partner, Male, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 14 Years	Mother's Partner, Male, 30 Years	Sexual Abuse	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that on multiple occasions, PS grabbed and squeezed SS1's buttocks in a sexual manner and exposed his penis. PS abused alcohol and would become violent and aggressive toward the CHN when impaired. PS struck SS1 across her face, grabbed her, and smashed plates over her head. SS1 had a history of self-harm and PS would encourage her to harm herself. PS would also lock the CHN in their bedrooms for extended periods of time. SM was aware of these concerns but failed to intervene.

Report Determination: Unfounded | **Date of Determination:** 12/13/2018

Basis for Determination:
SS1 initially reported the allegations in the report were true: there was one incident where PS exposed himself to all the CHN, and PS grabbed her buttocks more than once. Later, SS1 recanted and said she lied about everything alleged. SC and SS2 denied any safety concerns or that they were locked in their rooms. They also denied PS was inappropriate or physically aggressive. SS3 was born during this investigation and safe sleep was discussed. None of the CHN reported any alcohol misuse in the home. SS1 denied self-harming. SM, PS and MGM were concerned with SS1's behaviors and by the close of the case, SS1 was engaged in counseling. Those providers reported no CPS concerns to OCDSS.

OCFS Review Results:
During interviews, concerns that SS1 engaged in sexual activity with an adult were brought up. SM reported LE was involved and a SANE exam was completed on SS1; however, OCDSS did not speak with LE to confirm SM acted appropriately. There were no documented attempts to interview the children's biological fathers.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
During interviews, concerns that SS1 engaged in sexual activity with an adult were brought up. SM reported LE was involved and a SANE exam was completed on SS1; however, OCDSS did not speak with LE to confirm such, and that SM acted appropriately.

Legal Reference:

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

Action:

OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:

There were no documented attempts to interview the children's biological fathers.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

OCDSS will make efforts to make casework contacts with biological parents and/or other persons named in a report. Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/24/2018	Sibling, Female, 12 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 14 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 12 Years	Mother's Partner, Male, 30 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 12 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 14 Years	Mother's Partner, Male, 30 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 14 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

This SCR report was received with concerns that on 5/22/18, SM became angry with SS1 and began calling her vulgar names. SM yanked SS1 around by her hair and threw her out the door. On 5/23/18, SM slapped SS1 in the face. PS made SS1 move large rocks around as a form of punishment and forced SS2 to hold a large rock over her head for an extended period.

Report Determination: Unfounded | **Date of Determination:** 06/29/2018

Basis for Determination:

SM and PS explained they had learned SS1 had sex with her 15yo boyfriend, so they addressed this with that CH's father and punished SS1. LE was involved and confirmed this was accurate. SS1's punishment was yard work, which included picking up rocks. None of the CHN disclosed the rocks were heavy or that any excessive corporal punishment was used. SM reported she did become angry after learning about SS1's behavior and grabbed her by her hoodie, not her hair. SS2 denied she had to hold a rock. SM denied slapping SS1, and PS, SC nor the SSs corroborated this occurred. The school had no CPS concerns for the CHN. The case was unfounded and closed.

OCFS Review Results:

The record did not reflect if SS1's counselor was spoke with as a collateral source. There were no documented attempts to interview the children's biological fathers.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The record did not reflect if SS1's counselor was spoken with as a collateral source.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
There were no documented attempts to interview the children's biological fathers.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
OCDSS will make efforts to make casework contacts with biological parents and/or other persons named in a report. Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians.

[redacted]

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

From 2009 to 2016, SM was named as a subject in four unfounded reports with common allegations of IG, LS, and PD/AM.

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