Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-21-025

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

Issue Date: Apr 11, 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		
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
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 10/30/2021
Initial Date OCFS Notified: 10/31/2021

Presenting Information

An SCR report alleged that on 10/30/21, the 3-year-old subject child had a febrile seizure, while in the care of the mother. The mother called 911 at approximately 10:00 PM and the child was transported to the hospital by ambulance. The child was treated for his seizure at the hospital, and while being treated the child went into cardiac arrest. The child later died at the hospital at 11:15 PM. The cause of death was unknown. The child had no known medical condition that contributed to his death and he was an otherwise healthy child. The child had no visible injuries and the mother had no explanation for the child's death. The 4-year-old sibling and the roommate's 12-year-old child had unknown roles.

Executive Summary

On 10/31/21, the Monroe County Department of Human Services (MCDHS) received an SCR report regarding the death of the 3-year-old male child that occurred on 10/30/21. At the time of the child's death, he resided with his mother, 4-year-old sibling, the mother's roommate and the roommate's 12-year-old daughter. There was an 8-year-old sibling that resided with his father and the mother had not seen the sibling for two years. Attempts to locate and assess the safety of the 8-year-old sibling were unsuccessful. The father of the subject child was unknown. The 4-year-old sibling's father resided out of state, and he had no contact with the sibling. Attempts to locate and interview him were unsuccessful. The father of the roommate's 12-year-old child had no concerns and the child was assessed to be safe in her mother's care.

Upon investigation, it was learned that the mother, subject child and 4-year-old sibling were visiting a friend's home on the evening of 10/30/21. The children were playing in the living room when another child at the friend's home went into the kitchen and told the mother that the child was shaking. The mother ran into the living room, and she observed the child was having a seizure. The friend contacted 911 and she and the mother spoke to the dispatcher. EMTs arrived and transported the child to the hospital via ambulance. Life saving measures were unsuccessful and the child was pronounced deceased at 11:15 PM.

An autopsy was performed, and the final autopsy results had not been received at the time this report was written. Law enforcement investigated the incident and their case remained open pending the final autopsy results.

Following the child's death, the mother made statements of self-harm, so a safety plan was initiated that the mother and sibling would remain at a friend's home for a few days and the friend would supervise the mother's contact with the sibling. MCDHS made a referral to mobile crisis and the sibling was assessed to be safe in the friend's home. The mother continued to display mental health concerns, she left the roommate's home and became homeless. On 11/4/22, a safety plan was made for the sibling to reside with the maternal grandfather and for the mother's contact to be supervised until the mother engaged in mental health services and she found stable housing. On 12/7/21, MCDHS filed a Neglect Petition against the mother. At the initial appearance on 12/8/21, the sibling was placed in the custody of the grandfather under Article 1017 with the mother having supervised visitation. The mother enrolled in mental health counseling and the sibling received trauma-informed counseling services. The Neglect Petition was pending in Family Court at the time this report was written.

MCDHS substantiated the allegations of Inadequate Guardianship and Inadequate Food, Clothing, Shelter against the mother. The mother's untreated mental health concerns resulted in the mother often lashing out at the children and using physical discipline on them. The mother's roommate reported that she often had to care for the children since the mother

was overwhelmed and she would not wake up in the morning. Due to the mother making statements of self-harm following the child's death, she was unable to make sound decisions regarding the sibling's care. The mother had a history of unstable housing and she refused to obtain emergency housing, resulting in the sibling going into the grandfather's care. The allegation of DOA/Fatality was unsubstantiated against the mother. The mother obtained emergency medical care immediately when the child had a seizure. A cause of death had not yet been determined at the time the investigation closed. The child did not appear to have any signs of trauma and there was a lack of credible evidence that the child's death was caused by the mother's actions or inactions. The investigation closed on 12/15/21 and the case remained open for ongoing CPS services.

PIP Requirement
For citations identified in historical cases, MCDHS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) MCDHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDHS 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?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
The case was appropriately indicated and opened for ongoing CPS services.

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: 10/30/2021 **Time of Death:** 11:15 PM

Time of fatal incident, if different than time of death: 09:51 PM

County where fatality incident occurred: Monroe
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

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **In another room**

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	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other Adult - Roommate	No Role	Female	30 Year(s)
Deceased Child's Household	Other Child - Roommate's Child	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)
Other Household 1	Other Adult - Father of Roommate's Child	No Role	Male	29 Year(s)
Other Household 2	Other Adult - Father of 4-year-old Sibling	No Role	Male	33 Year(s)

LDSS Response

MCDHS reviewed SCR history and spoke to collaterals including the source of the report, law enforcement, mobile crisis, school staff, the mother's mental health counselor and the sibling's trauma therapist. They conducted home visits at the friend's home where the mother and sibling stayed following the fatal incident, at the mother's and her roommate's home, and at the maternal grandfather's home. They interviewed the mother, her friend, the roommate, the roommate's child, the grandfather, and the father of the roommate's child.

The mother reported that she and the children were at a friend's home on 10/30/21. She was in the kitchen and the child and sibling were running between the living room and kitchen playing with other children that were at the home. She said there was not an extended period where the children were not observed. One of the other children informed her that the child was in the living room shaking, and when she entered the living room, she observed the child having a seizure. She denied that the child had any diagnosed medical conditions or that he had ever had a seizure prior to the incident. She said the child had a slight cough and congestion, so she had been giving him over the counter children's pain reliever and rubbing a mentholated topical ointment on his chest from 10/26/21-10/29/21. She checked the child's temperature during that time, and he did not have a fever. She said 10/30/21 was the first day she had not given the child the pain reliever since his symptoms had improved.

The 4-year-old sibling stated that the child was "with God because he wouldn't wake up". He was unable to provide any additional details about the incident. He disclosed that the mother often physically disciplined them. The mother's roommate and her daughter expressed concerns that the mother often used physical discipline on the children and that the mother was overwhelmed caring for the children. They said the mother would not wake up with the children in the morning and she often left the children in the care of the roommate.

The mother's friend reported that the mother and children were visiting her home on 10/30/21 and she confirmed that the child was in the living room watching TV around 9:00 PM while the mother was in the kitchen with a few other adults. She said they were told there was something wrong with the child and when she went into the living room, she saw that the child was unresponsive, and he appeared to be having a seizure. She moved the child from a chair to the floor and she started CPR. She went to get a neighbor who was medically trained, and the mother would not let anyone touch the child. The friend added that her teenage child brought the sibling upstairs so he would not be aware of what was going on.

Law enforcement records stated that there were no visible signs of trauma to the child's body and the autopsy and lab results were pending. There were no drugs or paraphernalia found during a search of the friend's home following the incident. The mother's friend gave a statement to law enforcement that was consistent with her account to MCDHS.

EMS records showed they arrived on scene at 9:51 PM and the child was found lying on the floor and he was convulsing, very pale and unresponsive. He was hot to the touch and there were no injuries noted. The child stopped convulsing in route to the hospital, but he remained unresponsive with adequate respirations. The primary impression was that the incident was the result of a febrile seizure. Hospital records showed the child's heartrate dropped below 60 beats per minute at 10:30 PM and CPR was administered for 45 minutes. At 11:15 PM the child was declared deceased.

Medical records showed the child was last seen for a well-child visit on 10/19/21 and there were no medical concerns noted. It was documented that the mother had no concerns for the child's health, but she shared concerns that the child often had outbursts and tantrums.

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: The case was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059943 - Deceased Child, Male, 3 Year(s)	060008 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
059943 - Deceased Child, Male, 3 Year(s)	060008 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
060009 - Sibling, Male, 4 Year(s)	060008 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
060009 - Sibling, Male, 4 Year(s)	060008 - Mother, Female, 24 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:
Attempts to locate and interview the father of the 4-year-old sibling were unsuccessful.

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: Risk was adequately assessed and a Neglect Petition was filed to obtain court ordered services.				

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 sibling was placed in the custody of the grandfather under Article 1017 on 12/8/21.

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:**
12/07/2021	There was not a fact finding	There was not a disposition
Respondent:	060008 Mother Female 24 Year(s)	
Comments:	On 12/7/21, an Article 10 Neglect Petition was filed against the mother regarding the 4-year-old sibling. At the initial appearance on 12/8/21, the sibling was placed in the custody of the grandfather under Article 1017. The petition was pending in Family Court at the time this report was written.	

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	☐	☐	☐	☐	☐	☒	☐

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:
The sibling received trauma-informed counseling services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother engaged in mental health services.

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)
06/10/2020	Deceased Child, Male, 1 Years	Mother's Partner, Male, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Deceased Child, Male, 1 Years	Mother's Partner, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 1 Years	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 1 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 22 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 3 Years	Mother's Partner, Male, 24 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 3 Years	Mother's Partner, Male, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

	Sibling, Male, 3 Years	Mother's Partner, Male, 24 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report alleged the mother and her partner at the time were aware that the home was in deplorable condition. There was debris covering the floors and dirty dishes with rotting food on the floor. More than once, the dirty dishes on the floor resulted in shattered glass being strewn about the floors. As a result of broken glass on the children's bedroom floor, the now 4-year-old sibling sustained a laceration to his foot. There was a lock on the outside of the children's bedroom door. The adults locked the children inside the room then went outside for periods of time or went shopping while the children were unsupervised. The mother became out of control with anger and hit the children.

Report Determination: Unfounded | **Date of Determination:** 09/24/2020

Basis for Determination:
The mother and her partner at the time denied the allegations. The home was observed to be safe and not in deplorable condition. The subject child and now 4-year-old sibling were assessed to be safe in the mother's care. The family's whereabouts were unknown at the close of the investigation.

OCFS Review Results:
MCDHS assessed the home to be safe and they interviewed the mother and her partner. The subject child and sibling were observed to be free from cuts or other injuries. Safety Assessments and the RAP were completed timely and accurately and Notice of Existence was provided to the mother and her partner in a timely manner. Relevant collaterals were contacted. The family moved during the investigation and attempts were made to locate the family prior to closing the case. Diligent attempts were made to identify and locate the fathers of the siblings but were unsuccessful.

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)
10/06/2019	Deceased Child, Male, 1 Years	Other Adult - Cousin , Male, 22 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report alleged the mother's cousin drank alcohol and became verbally and physically abusive towards his partner in the presence of the cousin's unknown children and while he was babysitting the subject child on 10/5/19. The child was crying for about an hour and the cousin failed to attend to his needs. The cousin yelled at the children, telling them to shut up.

Report Determination: Unfounded | **Date of Determination:** 10/17/2019

Basis for Determination:
The investigation revealed that the cousin had no children. The cousin only babysat the child on occasion so he was not considered a person legally responsible for the child. The cousin was babysitting the child on 10/5/19. He reported that the child was throwing a tantrum so he let him cry until he calmed down. The cousin denied being verbally or physically abusive towards the child or his partner. The mother denied having any concerns for the cousin's care of the child. The child was found to be safe in the mother's care.

OCFS Review Results:
The cousin's home was assessed and the cousin and his partner were interviewed. The mother was interviewed about the allegations; however, attempts to identify the child's father were not made. Notice of Existence was not provided to the cousin, his partner who resided in the home, or the mother.

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

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

Summary:

Attempts to identify the child's father were not documented.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

MCDHS will make casework contacts per the following regulation: 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, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:

Failure to provide notice of report

Summary:

Notice of Existence was not provided to the cousin, his partner, or the mother.

Legal Reference:

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

Action:

MCDHS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/18/2019	Other Child - Partner's Child , Female, 8 Years	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Partner's Child , Female, 8 Years	Mother's Partner, Male, 23 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 23 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 2 Years	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 2 Years	Mother's Partner, Male, 23 Years	Lack of Supervision	Unsubstantiated	
	Other Child - Partner's Child , Female, 8 Years	Mother's Partner, Male, 23 Years	Excessive Corporal Punishment	Unsubstantiated	
	Deceased Child, Male, 7 Months	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 7 Months	Mother's Partner, Male, 23 Years	Lack of Supervision	Unsubstantiated	

Report Summary:

An SCR report alleged the mother's partner at the time left his child, the subject child, and the now 8 and 4-year-old siblings home alone for approximately 30 minutes.

Report Determination: Unfounded **Date of Determination:** 10/30/2019

Basis for Determination:

The mother's partner resided with the mother and his child visited him on weekends. The mother's partner cared for the subject child and siblings while the mother was at work. The partner's child stated that the partner left the children home

alone for 30 minutes while he went to the store. The partner stated that he was outside smoking a cigarette while the children were sleeping and he denied leaving them home alone. The mother denied that she or her partner left the children unsupervised. The mother and her partner did not have stable housing and they were residing in a shelter at the time the case closed. MCDHS offered Preventive Services to the family and they declined.

OCFS Review Results:
Home visits were conducted and the mother, her partner and the children were interviewed. The mother of the partner's child was interviewed and her home was assessed. Safety Assessments and the RAP were completed timely and accurately. Notice of Existence was provided to the mother, her partner and the mother of the partner's child late on 5/20/19. Attempts were made to locate the fathers of the subject child and siblings, but were unsuccessful. Relevant collateral contacts were made.

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

Issue:
Failure to provide notice of report

Summary:
Notice of Existence was provided to the mother, her partner and the mother of the partner's child late on 5/20/19.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
MCDHS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

[redacted]

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

An SCR report dated 3/24/18 was unsubstantiated for the allegations of Inadequate Guardianship against the mother regarding the now 8 and 4-year-old siblings.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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