Child Fatality Report

Report Identification Number: SY-21-008

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

Issue Date: Jul 27, 2021

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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 23 day(s)
Jurisdiction: Cayuga
Gender: Male
Date of Death: 02/07/2021
Initial Date OCFS Notified: 02/07/2021

Presenting Information

Cayuga County Department of Social Services (CCDSS) received an SCR report which alleged on 2/7/21, while in the care of the mother and the father, the 23-day-old subject child was found unresponsive with a white milky substance around his nose and mouth at approximately 6:00AM. The mother yelled to the father to call 911. The mother fed the child between 4:45AM and 5:00AM. She then placed him back in his bassinet that was in the living room next to the couch where the whole family was sleeping. The bassinet had a small stuffed toy that was hanging into the bassinet but not reaching the mattress. It was unknown if there were any other objects in the bassinet or if the hanging toy reached the child or child's face. Emergency medical services later arrived and transported the child to the hospital. The child was otherwise healthy and there was no explanation provided for his death.

Executive Summary

On 2/7/21, CCDSS received an SCR report regarding the death of the 23-day-old male subject child. The child resided with his mother, father and 9-year-old and 1-year-old siblings. The mother had two other children, ages 7 and 5 years old, who resided with their father and had frequent visitation with the mother at her home.

Through a joint investigation with law enforcement, it was learned that on the morning of 2/7/21, the child was at the home with the parents, 1yo, 5yo and 7yo siblings. The 9yo sibling was visiting with a grandparent. The family was sleeping in the living room after a family game and movie night. The mother woke several times throughout the night to feed and burp the child. After each feeding, the mother placed the child to sleep in a bassinette. At approximately 6:00AM, the mother checked on the child and found him unresponsive. The mother woke the father and he called 911 and initiated CPR per the instruction of the 911 dispatcher. First responders arrived and transported the child to the hospital via ambulance. Attempted life saving measures continued at the hospital; however, they were not successful and the child was pronounced deceased.

An autopsy was performed and the manner of death was natural. The cause of death was congenital cardiovascular anomaly with the contributing factor being hyperbilirubinemia (jaundice). Law enforcement determined there was no criminality regarding the fatality and closed their investigation.

CCDSS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother and father due to the findings of the autopsy report. CCDSS opened a Preventive Services Case for the family and provided short term intensive home based services. The family was given information on mental health counseling, funeral assistance and parent education. The investigation was closed on 6/28/21.

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?** No

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:
In a prior case, the SM was a PLR for an unrelated child who died. Due to this and the SC's death, CCDSS stated that the SSs were in immediate or impending danger of serious harm and recorded safety decision #3 on the 24-hour, 7-day and 30-day safety assessments. Although there was a safety factor present, the facts of the case did not support the safety decisions.

Was the decision to close the case appropriate? Yes

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 BF of the 7yo and 5yo SSs had custody of the children and it was not documented that his home was assessed for safety. CCDSS documented an interview of the SF regarding the fatality and that further details were contained on the video recording of the interview at the police station; however, it was unclear if the SF was asked questions about overall safety and risk.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP did not identify a secondary caretaker, despite the father having a regular caretaking role for the siblings. The mother's mental health concerns were not reflected in the RAP.
Legal Reference:	18 NYCRR 432.2(d)
Action:	CCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	More than half of the progress notes were entered more than a month after their event dates.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:	Pre-Determination/Home Visit
Summary:	The record reflected that the 5yo and the 7yo siblings resided at their father's home; however, it was not documented that his home was assessed for safety.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(a)
Action:	Prior to a determination being made, the investigation must include one home visit so as to evaluate the environment of the child named in the report as well as other children in the same home.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/07/2021 **Time of Death:** Unknown

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

County where fatality incident occurred: Cayuga
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? N/A
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? 1 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☒ Asleep
- ☐ Absent
- ☐ 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	23 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)

Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Other Household 1	Other Adult - Father of 9yo sibling	No Role	Male	31 Year(s)
Other Household 2	Other Adult - Father of 7yo and 5yo siblings	No Role	Male	30 Year(s)
Other Household 2	Sibling	No Role	Male	7 Year(s)
Other Household 2	Sibling	No Role	Female	5 Year(s)

LDSS Response

CCDSS investigated the incident by searching SCR history and speaking to the source of the report, the mother, father, father of the siblings and surviving siblings. They made collateral contacts with law enforcement and obtained records from emergency medical services and the medical examiner.

Through interviews with the parents, it was learned that the child had been hospitalized from 1/26/21 to 1/29/21 due to having high bilirubin levels. The subject child had jaundice and the mother stated that the discharge instructions were to follow-up with the primary care physician and to add two ounces of formula to his feedings. It was unclear if the parent's followed up with the pediatrician. The parents did not report any concerns for the child between his discharge from the hospital and his death.

CCDSS and law enforcement interviewed the mother at the police station. The night leading up to the fatality the family slept in the living room because they were having a family game and movie night. Everyone had fallen asleep between 10:00PM and 10:30PM and the subject child slept in a travel bassinette. The mother denied that there were any pillows or blankets in the bassinet but that there was a toy in it that came with the bassinette. The mother denied that they co-slept with the child. The mother fell asleep around 12:00AM and woke back up around 2:00AM to feed the child. The mother nursed the child and gave him two ounces of formula, changed his diaper and put him back in the bassinet. The mother woke up between 4:00AM and 4:30AM to feed the child again. The mother stated that this feeding was just like the previous one and she placed him back in his bassinette. The mother reported she had burped the child after both feedings and that he spit up when being burped, which was typical for him. The mother went to check on the child around 6:00AM and found him not breathing. The child’s head was turned to the left and he had a white, milky substance coming from his nose and mouth and a little bit of blood. The mother yelled for the father to call 911. The father was instructed on CPR by 911 dispatch until first responders arrived.

The father provided similar details to the mother's accounts of the incident. The father reported he had fallen asleep while the family watched the movie. He woke up in the night and observed the mother holding the child, but was unsure what time it was. The father was then woken by the mother screaming for him to call 911.

CCDSS assessed for the safety of the surviving siblings within 24 hours of receipt of the SCR report. The 9yo, 7yo and 5yo siblings were interviewed at the child advocacy center and they reported the mother co-slept with the subject child and the night of the fatality the mother co-slept with the child on the couch. CCDSS conferenced with their legal department and determined they would not file a family court petition. It was learned through the historical case review and fatality review that the mother previously had an unrelated child die while in her care; however, there were no allegations against her related to the death. Due to the prior fatality and death of the subject child, CCDSS requested that the parents sign a safety plan, which required them to have supervised contact with the siblings. The parents refused and CCDSS opened the family to intensive home based services, which consisted of several contacts with the family per week. There were also concerns for the 9yo sibling's education and CCDSS assisted the family in enrolling the child for in-person learning, as she had struggled to participate in remote school. The parents' home was assessed for safety and concerns regarding clutter were addressed. The home of the father of the 7yo and 5yo siblings was not documented as being assessed.

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)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057501 - Deceased Child, Male, 23 Day(s)	057502 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
057501 - Deceased Child, Male, 23 Day(s)	057502 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
057501 - Deceased Child, Male, 23 Day(s)	057504 - Father, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated
057501 - Deceased Child, Male, 23 Day(s)	057504 - Father, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
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:
It was documented that the 9yo sibling did not have face-to-face contact with her father. CCDSS notified him in writing of the SCR report but the record did not reflect that he was interviewed regarding the SCR report.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

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

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	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The mother had a history of substance use and self reported she had been on medication and was compliant with her treatment recommendations. The family was provided information on mental health counseling, parent education and funeral assistance. CCDSS opened a Preventive Services Case for the family and they were provided with six weeks of intensive in home services.

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 parents were offered mental health counseling on behalf of the siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:
CCDSS opened a Preventive Services Case for the family and they were provided with six weeks of intensive preventive services following the fatality. In addition, the parents were offered funeral assistance, mental health counseling and parent education.

History Prior to the Fatality

Child Information

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

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)	Allegation Outcome	Compliance Issue(s)
03/14/2019	Sibling, Female, 5 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
Onondaga County Department of Social Services (OCDSS) received an SCR report which alleged the then 5yo sibling received stitches above his eye from falling. The mother scrubbed the stitches out of the wound with a wash cloth. These stitches were not dissolvable and were not supposed to be removed until 3/18/19. As a result, the 5yo's incision had some blood and she was in pain but the wound did not re-open.

Report Determination: Unfounded | **Date of Determination:** 04/22/2019

Basis for Determination:
OCDSS determined there were inconsistent accounts provided by the family as to how the stiches were removed from the sibling's head; however, there was no evidence that the mother maliciously removed them or that the removal of the stiches had an adverse effect on the sibling. OCDSS determined there was no further CPS action necessary and the report was unfounded and closed.

OCFS Review Results:
OCDSS completed required casework contacts, spoke to collaterals, provided notification of existence letters, completed

home visits, provided the mother with safe sleep guidance, and completed assessments on time and with accurate information. There was supervisory consultation documented throughout the investigation. Although OCDSS obtained information about the sibling that was born during the investigation and assessed his safety, he was not added to the report.

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

Issue:
A child was born during an open CPS investigation and not added to the report

Summary:
Although OCDSS obtained information about the sibling that was born during the investigation and assessed his safety, he was not added to the report.

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

Action:
OCDSS is required to obtain the name, age, and condition of other children in the home. OCDSS will add all appropriate household members to open investigations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/07/2018	Sibling, Female, 6 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	No
	Sibling, Female, 6 Years	Mother's Partner, Male, 25 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 6 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6 Years	Mother, Female, 26 Years	Lack of Medical Care	Substantiated	
	Sibling, Female, 6 Years	Mother's Partner, Male, 25 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6 Years	Mother's Partner, Male, 25 Years	Lack of Medical Care	Substantiated	
	Other Deceased Child - Mother's partner's child-unrelated, Male, 1 Years	Mother's Partner, Male, 25 Years	DOA / Fatality	Unsubstantiated	
	Other Deceased Child - Mother's partner's child-unrelated, Male, 1 Years	Mother's Partner, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
Jefferson County Department of Social Services (JCDSS) received an SCR report which alleged on 10/7/18, at approximately 9:37AM, the 1yo child of the mother's partner was brought to the hospital by ambulance. The mother's partner found the child in his bed with blue fingertips and not breathing. He last saw the child at 8:30PM when he laid him down alone in a bedroom to go to sleep. At that time, the child was reported to be fine, he was not ill, and he had no preexisting medical conditions. The child was otherwise healthy and the mother's partner had no explanation for the unrelated child's death.

Report Determination: Indicated | **Date of Determination:** 04/16/2019

Basis for Determination:
An autopsy was performed and it concluded that the cause and manner of the unrelated child's death was undetermined. As a result of the autopsy report, JCDSS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship

against the mother's partner. During the investigation it was discovered the mother and her partner were selling the then 6yo sibling's medication for gas money. As a result, the sibling was not receiving her medication as prescribed. Therefore, allegations of Inadequate Guardianship and Lack of Medical Care were added and substantiated against the mother and her partner.

OCFS Review Results:
JCDSS coordinated their investigation with law enforcement and utilized the child advocacy center for the interviews of the surviving children. JCDSS completed required casework contacts, spoke to several collaterals and offered the family services in response to the death of the unrelated child. The mother was pregnant and JCDSS provided her with information on safe sleep. There was supervisory consultation documented throughout the investigation.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/26/2018	Sibling, Female, 6 Years	Mother, Female, 26 Years	Lacerations / Bruises / Welts	Unsubstantiated	Yes
	Other Child - Unrelated, Female, 5 Years	Mother's Partner, Male, 25 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 26 Years	Poisoning / Noxious Substances	Unsubstantiated	
	Other Child - Unrelated, Female, 5 Years	Mother, Female, 26 Years	Excessive Corporal Punishment	Substantiated	

Report Summary:
Jefferson County Department of Social Services (JCDSS) received an SCR report which stated the mother threw the then 6-year-old sibling. As a result, the sibling sustained bruising from her upper hips to her buttocks. Approximately a year prior to the SCR report, the then 1-year-old sibling gained access to the mother's medication and ingested an unknown amount. As a result, the sibling spent time in the pediatric intensive care unit.

Report Determination: Indicated | **Date of Determination:** 07/09/2018

Basis for Determination:
JCDSS substantiated IG and XCP regarding the unrelated child. Two of the CHN made disclosures that the SM put a baby wipe in the unrelated child's mouth and duct taped her mouth shut. The unrelated child reported that she had a hard time breathing. The BF of the unrelated child was present and did not intervene. Collateral contacts reported the unrelated child disclosed the same story to them. JCDSS found no credible evidence to substantiate IG, L/B/W and P/Nx. The SSs and unrelated child made no disclosures regarding the unsubstantiated allegations and no marks were visible on the 6yo SS. The allegation of P/Nx was investigated previously and indicated on 04/13/17.

OCFS Review Results:
JCDSS spoke to the source, completed several home visits, completed face-to-face interviews, spoke to several collaterals, completed assessments on time and with accurate information and entered all notes contemporaneously with their event date. JCDSS notified absent parents of the SCR report. There was detailed supervisory consultation documented throughout the investigation. Early intervention referrals were completed for the 2yo sibling and 1yo unrelated child. It was determined in a prior investigation that there was credible evidence to substantiate P/Nx against the mother; however, JCDSS unsubstantiated the same allegation in this CPS investigation.

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

Issue:
Appropriateness of allegation determination
Summary:
It was determined in a prior investigation that there was credible evidence to substantiate P/Nx against the mother; however, JCDSS unsubstantiated the same allegation in this CPS investigation.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
JCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Syracuse Regional Office if further guidance is needed.

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

In 2014, the mother had one unfounded CPS investigation in Jefferson County with allegations of inadequate guardianship regarding the 9yo and 7yo siblings.

In 2017, the father of the 7yo and 5yo siblings and the mother had one substantiated CPS investigation in Onondaga County with allegations of inadequate guardianship and poisoning/noxious substance regarding the 5yo sibling.

In 2017, the father of the 7yo and 5yo siblings, and mother had a CPS FAR case in Jefferson County with concerns of inadequate guardianship, inadequate food/clothing/shelter and lacerations/bruises/welts regarding the 5yo and 7yo siblings.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

In 2018, the mother was considered a person legally responsible for an unrelated child; that child died while in her care. Following the death, the family was opened to preventive services in order to receive assistance with services. The case was closed once the family was connected to services.

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