Child Fatality Report

Report Identification Number: NY-21-117

Prepared by: New York City Regional Office

Issue Date: May 10, 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 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 11/14/2021
Initial Date OCFS Notified: 11/14/2021

Presenting Information

On 11/13/21, the parents were at home when their three-month-old son was placed in an unknown area in the home to sleep. On 11/14/21, at approximately 10:50AM, the parents checked on the SC and found him unresponsive; they called 911. EMS responded to the home, observed the SC in cardiac arrest and transported him to the hospital. The SC was pronounced dead at 11:27AM on the same morning. No plausible explanation was given regarding the SC cause of death.

Executive Summary

This fatality report concerns the death of a three-month-old male subject child (SC) who died on 11/14/21. The allegations were DOA/fatality and IG of the SC by the parents and the PGM. The family declined an autopsy due to religious reasons; however, an examination was completed by the ME. The SC was buried on 11/15/21. The Medical Examiner ruled the cause and manner of death as undetermined.

ACS learned that at the time of the incident, the SC was in the care of the PGM at the PGM's home where the SC spent most weekends. However, the SC resided with his parents, and nine and eighteen-year-old siblings at the case address. The father has two children from previous relationships that reside with their biological mothers, elsewhere. The family refused to provide contact information for those children to be assessed by ACS. The PGM was deemed a person legally responsible for the SC. Residing with the PGM were the seventeen, twenty-two and twenty-four-year-old PAs.

ACS learned that the PGM shared a king size bed with the SC and the seventeen-year-old PA, who is non-verbal and autistic. Although the parents were aware of the dangers of bed-sharing with infants, they did not provide adequate sleep accommodations for the SC at the PGM's home where he spent most weekends. The PGM awoke and found the SC unresponsive. LE found no criminality. EMS reported upon arrival, they observed the SC on the floor with compressions being administered by a family member, as instructed by the dispatch operator.

The nine and seventeen-year-children were deemed safe and remained in the homes with their respective families. Neither child exhibited change in their behaviors.

The SC's pediatrician reported the parents were involved in the SC's medical visits and safe sleep was discussed. The collaterals had no concerns regarding the PGM and the care she provided.

On 1/26/22, ACS unfounded the DOA/fatality and IG allegations of the SC by the mother, father and PGM citing no credible evidence was found to suggest abuse or maltreatment of the SC. ACS noted that the ME ruled the cause and manner of the SC's death undetermined, and the children were up to date with their physicals and immunizations. ACS closed the case and family refused services.

NYCRO does not agree with ACS' decision to unsubstantiate the allegations of the report. The SC was bed sharing with the SC and another individual. The parents although they were aware of safe sleep practices, failed to provide the appropriate sleep surface for the SC.

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

Was the decision to close the case appropriate? Yes

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:

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Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The SC was bed sharing with the SC and another individual. The parents, although they were aware of unsafe sleep practices, failed to provide the appropriate sleep surface for the SC; yet, ACS unsubstantiated the allegations.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or has taken to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Child Fatality Report

Date of Death: 11/14/2021 **Time of Death:** 11:27 AM

Time of fatal incident, if different than time of death: 10:50 AM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 10:55 AM
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
How long before incident was the child last seen by caretaker? 5 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	Adult Sibling	No Role	Female	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Other Household 1	Aunt/Uncle	No Role	Female	17 Year(s)
Other Household 1	Aunt/Uncle	No Role	Female	24 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	54 Year(s)
Other Household 1	Other Adult - PGM's goddaughter	No Role	Female	22 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS initiated an investigation by contacting hospital staff who reported the SC had surgery three weeks prior; however, it was unknown whether the surgery played a part in his death. The ME reported the cause and manner was undetermined. LE found no criminality and closed their case.

On 11/14/21, the Specialist interviewed the PGM who reported she shared the bed with the SC as the crib was at the SC's home. The parents dropped the SC off at her home on 11/12/21 at 8:00PM. The parents stopped by to see the SC the following day at approximately 11:00AM. On 11/14/21,The PGM woke up at 5:00AM, fed the SC and he fell asleep at 5:45AM, he did not spit up. She woke up at 10:45AM and noticed the SC was unresponsive; she called 911 and initiated CPR. The PGM reported she shared a king size bed with the SC and the seventeen-year-old PA who is autistic and nonverbal. The PGM explained that she and the PA slept vertical while she placed the SC horizontal and, on his back, between them. The SC's feet were at the PGM's stomach area. The SC was propped with a pillow that had a depression in the center and another small pillow under that pillow. The SC was covered with a baby blanket up to his chest with the blanket tucked under his arms.

ACS interviewed the twenty-four-year-old PA who reported she was in the basement part of the home when the incident occurred. She ran upstairs and was instructed by the PGM to open the door for EMS as the SC was not breathing. The PA observed the PGM applying CPR to the SC who was laying on his back, on the floor. The PA reported the SC was fussy during the night of 11/12/21 when she provided care. She reported the SC turned himself often in various positions as he slept. At the time of the discovery, the PGM or the PA reported the seventeen-year-old was asleep until EMS entered the home.

On 11/14/21, the parents allowed the ACS Specialist to see the nine-year-old SS at the door of the home; however, they did not allow an assessment or interview. The parents became less resistant, and the family were interviewed prior to closing the investigation. The parents and the PGM denied mental illnesses, DV or drug/alcohol use in their homes.

On 11/16/21, ACS received information from the school staff stating the SS was struggling academically; however, he had shown improvement by the close of the investigation.

On 11/17/21, ACS received information from the pediatrician who reported the SS was last seen on 4/17/21 and is up to date with physicals and immunizations. The adult sibling refused to take part in the interviews.
On 11/18/21, ACS interviewed the PGA who resides in another apartment in the PGM's home, and she reported the family were very close and supportive of each other with no concerns. ACS also interviewed collaterals who reported no concerns.

ACS held a CSC on 11/26/21, with the parents and PGM in attendance. The parents agreed to allow ACS into the home to assess the SS. The family declined services; however, accepted information regarding services.
The SS and the seventeen-year-old children were deemed safe, they returned to school and displayed no changes in behavior. All collaterals reported no concerns with the family.

On 12/20/21, ACS unsubstantiated the allegations of DOA/fatality and IG of the SC by the parents and PGM citing the ME ruled the cause and manner of death undetermined. ACS wrote that the result of their investigation found no credible evidence to suggest maltreatment of abuse occurred or played a part in the SC's demise. ACS noted there were no signs of maltreatment or abuse found, the SC was up to date with immunization and physicals and LE found no criminality. The family declined services and ACS closed the case.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Unknown
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? No
Comments: There is no OCFS approved child fatality review team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060309 - Deceased Child, Male, 3 Mons	060311 - Mother, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
060309 - Deceased Child, Male, 3 Mons	060311 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
060309 - Deceased Child, Male, 3 Mons	060312 - Father, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
060309 - Deceased Child, Male, 3 Mons	060312 - Father, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
060309 - Deceased Child, Male, 3 Mons	060314 - Grandparent, Female, 54 Year(s)	DOA / Fatality	Unsubstantiated
060309 - Deceased Child, Male, 3 Mons	060314 - Grandparent, Female, 54 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?	☒	☐	☐	☐

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: The two minor children reportedly did not exhibit any behavioral changes; the parents declined 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?	☐	☒	☐	☐

Explain as necessary:
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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	☐	☐	☐	☐	☐	☒	☐

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? No
Explain:
The family declined services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The family declined services.

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? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/13/2021	Sibling, Male, 9 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 9 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 17 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 17 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The father and mother (names unknown), were always abusiing drugs, getting high in the home directly in front of the children ages 17,15 and 10 years old. The father had mental health issues and was selling drugs out of the home even when the children were visiting. The father always blasted music loudly all day long and during the nights; it kept the chlidren awake and restless.

Report Determination: Unfounded | **Date of Determination:** 08/27/2021

Basis for Determination:
ACS documented the results of their investigation that the mother had been providing the minimum degree of care to her children and that she did not allow them to visit their father due to concerns with criminal behavior at his home. The SM was 9 months pregnant at the time of the report and gave birth to a healthy baby. ACS noted that the SM did not have a 15-year-old child in the home and stated the neighbor maliciously called in numerous reports.

OCFS Review Results:
ACS initiated the report timely and made the appropriate contacts. Notices were provided and case decisions were supported by information contained in the case record.

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)
04/20/2021	Sibling, Male, 9 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 9 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 9 Years	Sibling, Female, 17 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 9 Years	Sibling, Female, 17 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The father was selling unknown drugs from the home in the presence of the children,11 and 15 year-old-males and 16 year-old female. The father was also abusing crack cocaine and other unknown substances to the point of impairment when providing care to the children. The father became hostile and violent to other while he was impaired. It was unknown whether the children sustained injuries. The father left substances and various illegal firearms easily accessible to the children. The mother was aware of the father's substance abuse and illegal activity and allowed the 11 year-old to reside in the home.

Report Determination: Unfounded | **Date of Determination:** 06/18/2021

Basis for Determination:
ACS wrote there was no credible evidence found that the mother failed to provide the 9 and 17-year-old children with the minimum standard of care. The chiildren reported all their needs were met, and they were in no danger; as they visited the PGM who was ailing and died; the mother stayed with them throughout the visit. ACS noted the mother filed for full custody and the father had not availed himself to be interviewed.

OCFS Review Results:
ACS made diligent efforts to contact the father to no avail.

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)
02/15/2021	Sibling, Male, 9 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 9 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The father was selling drugs from the home in the presence of the three unknown children ages 16, 9 and 5-years-old. The grandmother and mother (name unknown) to the two youngest are aware and fail to intervene. The mother and father abuse unknown drugs to the point of impairment while caring for the 5 and 9-year-old children. The mother and father scream and swear at each other loudly.

Report Determination: Unfounded | **Date of Determination:** 04/16/2021

Basis for Determination:
ACS found no credible evidence that the mother failed to provide the children with a minimum stndard of care. The mother reported she took the children to visit their ailing grandmother and she stayed with them throughout the visit. The mother filed for full custody of the 9-year-old child and the father failed to avail

OCFS Review Results:
ACS made diligent efforts to contact and interview the father to no avail.

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)
07/29/2019	Sibling, Female, 16 Years	Mother, Female, 37 Years	Childs Drug / Alcohol Use	Unsubstantiated	No
	Sibling, Female, 16 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The mother allowed a boyfriend to visit the home and sell crack from her bedroom, in the presence of the children. The mother allowed the 16-year-old to smoke marijuana. The home was often full of smoke from cigarette and other drugs. Both children have asthma. The mother often screamed at the autistic child and shook him to awake in the morning and he was afraid to return to the mother's home.

Report Determination: Unfounded | **Date of Determination:** 09/30/2019

Basis for Determination:
ACS wrote their investigation found no evidence that the mother was not providing adequate care for the children.

OCFS Review Results:
The documentation noted that the mother was diagnosed with a mental health condition to which she was prescribed medication. The SM refused to take them and her Dr recommended she attend services. ACS unfounded and closed the case with no services not knowing whethet it would negatively affect the mother's ability to provide adequate care to the children.

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)
10/28/2018	Sibling, Male, 6 Years	Mother, Female, 35 Years	Educational Neglect	Unsubstantiated	No
	Sibling, Male, 6 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The six-year-old child had been absent from school 11 days of the school year and had a history of poor attendance as he missed an excessive number of days the previous year. As a result he was falling behind. The child is a special needs child who received spech, occupational and other srvices at school and was not receiving the services as a result of not attending school. School staff attempted to reach out to the mother on multiple occasions regarding the child's attendance to no avail. The mother had missed a scheduled meeting to discuss the child's education.

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

Basis for Determination:
ACS wrote that the mother had been working with the school to obtain busing for the child that he was entitled to as he had been diagnosed with Autism the previous year. The mother had difficulty transporting the child on public transportation due to his medical condition. The transportation issue had been resolved. ACS also wrote that the mother provided a minimum degree of care to the children.

OCFS Review Results:
The investigation was conducted appropriately. ACS reviewed allegations and investigatory information against statutory and regulatory standards and made an appropriate determination.

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

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

According to the ACS documentation, in 2003, the mother and newborn tested positive for marijuana. The mother had two other indicated cases for PD/AM in 2004. She then enrolled in a substance abuse program and parenting skills. The mother was a known subject in 13 reports to the time of the fatality. Of the 13 reports, 5 unfounded, 5 indicated and 3 suspended.

The allegations of the indicated reports were LBW of the now AS and the SS. DV was committed against the mother in the presence of the children. There was an active OP which the mother violated in 2016 because she allowed the now SS to be around his father. The allegation of IG against her was substantiated. The mother was referred to PPRS.

Known CPS History Outside of NYS

There was no known 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