Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-21-053

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

Issue Date: Jun 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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 13 year(s)
Jurisdiction: Oswego
Gender: Male
Date of Death: 12/16/2021
Initial Date OCFS Notified: 12/17/2021

Presenting Information

On 12/15/2021, Oswego County Department of Social Services (OCDSS) received an SCR report concerning a house fire involving the mother, subject child, and sibling. The house fire occurred on 12/15/21 and the subject child died on 12/16/21 from injuries sustained during the fire. OCDSS completed a 7065 Agency Reporting form and notified the Syracuse Regional Office on 12/17/2021.

Executive Summary

This fatality report concerns the death of a 13-year-old male subject child. At the time of the child's death, he resided with his mother and 17-year-old sibling. The record revealed the father of the subject child and sibling died in 2016. The home where the mother, subject child, and sibling resided caught fire in the early morning of 12/15/21. The subject child was rescued from the home by first responders and transported to the hospital. The sibling jumped out of a second story window and sustained minor injuries. The mother perished in the fire. On 12/16/21, the subject child succumbed to injuries sustained during the fire.

The record did not reflect where in the home or how the fire started. The sibling woke to find his room filled with smoke and was able to exit the home through his window. Once outside, the sibling was unable to gain entry back into the home as it was engulfed in flames. The sibling thought he heard his mother inside the home yell, "don't go that way" to the subject child. The sibling went to a neighbor's home to alert them to call 911. The record did not reflect communication with first responders regarding the incident. The subject child was transported to the hospital with burns to 77% of his body.

OCDSS met with family members and developed a safety plan for the care of the sibling as both the mother and father were deceased. The maternal grandparents arrived from out of state and went immediately to family court to petition for custody of the sibling. Custody was granted and the sibling moved with the family out of state. The record did not reflect the outcome of the law enforcement investigation nor the fire investigation. The record did not reflect whether the subject child's death was referred to the medical examiner's office. The sibling was observed and deemed safe in the care of the maternal grandparents by CPS in the state where they resided. The investigation opened at the time of death was unfounded and closed after being referred to community-based services.

PIP Requirement
For issues identified in historical cases, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
The death of the subject child was not reported to the SCR, therefore, safety assessments and a determination were not required.

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:
There was minimal detail gathered and documented regarding the child's death. Based on the information OCDSS gathered, they determined there was no reasonable cause to suspect the death was a result of abuse or maltreatment. OCDSS closed their investigation once the sibling moved out of jurisdiction and services were offered.

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: 12/16/2021 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 12/15/2021
Time of fatal incident, if different than time of death: Unknown

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

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

☐ Other

Did child have supervision at time of incident leading to death? Unable to determine

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	13 Year(s)
Deceased Child's Household	Mother	No Role	Female	43 Year(s)
Deceased Child's Household	Sibling	No Role	Male	17 Year(s)

LDSS Response

OCDSS received an SCR report on 12/15/21 regarding the housefire, which occurred on the same date. OCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. OCDSS learned of the subject child's death following a text from the hospital social worker on 12/16/21. OCDSS notified the Syracuse Regional Office and submitted the required 7065 Agency Reporting Form.

On 12/15/21, OCDSS contacted the maternal family who resided out of state. The family was in transit to New York to make funeral arrangements for the mother and plan for the sibling and subject child.

OCDSS spoke with medical personnel and learned the subject child's condition was classified as "grave." The child had burns to 77% of his body and was not expected to survive. OCDSS observed the subject child, who was unresponsive and on life support. The sibling was hospitalized due to injuries sustained from jumping out of his window. The record revealed the sibling suffered from "back pain" but there were no medical records included in the case record with a diagnosis or injuries. The sibling was discharged from the hospital upon the arrival of his maternal grandparents on 12/16/21.

OCDSS spoke with the maternal grandparents at the hospital on 12/16/21 and gathered background information on the mother, subject child, and sibling including the mother's mental health, employment history, and familial relations. OCDSS spoke with a child welfare specialist in the state where the family resided to learn that the maternal grandparents did not have any relevant child welfare involvement nor criminal history. OCDSS assisted the family in navigating the family court system to petition and obtain custody of the sibling.

OCDSS spoke with the sibling and documented that he appeared "physically well." The sibling reported he was unaware of how or where the fire started. Sometime during the night he got medication from his mother and nothing appeared out of the ordinary at that time. The sibling said the mother regularly lit candles and burned sage in the living room, but was unaware if anything was burning on the night of the fire. He reported that around 1:00AM, he woke to find his room filling with smoke. He wrapped himself in a blanket and jumped out of his second floor window. He saw the home was engulfed with flames and ran to a neighbor's house to call 911. The record did not reflect a conversation was had with the sibling surrounding the mother's mental health or if she was experiencing paranoia or delusions in the days leading up to the fire or on the day of the fire.

Historically, there were concerns for the mother's mental health. Reports were made from 2019 through 2021 regarding the mother's mental health and the negative impact it had on her ability to parent, maintain stable employment, and interpersonal relationships. Multiple collateral sources expressed concern for the mother's mental health and OCDSS witnessed the mother having a mental health crisis during a home visit in 2020. The mother exhibited paranoia, spoke to OCDSS of hearing voices, and experienced delusions in the presence of OCDSS staff. The mother told OCDSS that there were people in the woods watching her and attempted to show OCDSS. OCDSS did not see nor did they hear anyone. OCDSS did not offer preventive services, and unfounded and closed previous investigations related to concerns for mental health without following up with community-based resources. The record did not reflect whether the mother's mental health was stable at the time of the fire and there were missed opportunities to gather information from collateral sources as to the status of the mother's mental health. An historical investigation reported the children had not been seen by medical professionals since 2018. The record did not reflect whether there were medical concerns for the children nor were medical collaterals contacted in the previous investigations. The landlord reported the mother had not allowed the children outside in over a year and the school reported the children were homeschooled and had not been seen for in person learning. OCDSS spoke with a neighbor who expressed concerns for the safety of the subject child and sibling, though those concerns were not further explored.

OCDSS spoke with the hospital, school officials, and out of state child welfare providers. OCDSS offered the family services in response to the fatality, but the grandparents and sibling declined a need for services. OCDSS found no evidence to support the allegations in the report open at the time of the death. OCDSS followed up with the grandparents and sibling via video call and assessed the sibling to be safe with his grandparents.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐

Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The record did not reflect contact with first responders, nor fire investigators, though the record confirmed they were involved. This was not an SCR-reported fatality; therefore, certain investigative activities were not required.

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?	☐	☐	☒	☐

Explain:
This was not an SCR reported fatality; therefore, safety assessments were not required. OCDSS assessed the safety of the sibling and determined him to be safe with the maternal grandparents.

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 maternal grandparents and sibling were referred to community-based mental health 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 mother perished in the housefire and the father died several years prior, thus the surviving sibling was informally placed with the maternal grandparents and moved out of state.				

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:
OCDSS provided the family with gift cards for clothing and necessities for the sibling. Community-based mental health services were offered and declined.

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:
CPS in the state where the sibling moved provided community-based referrals for mental health counseling and bereavement services. The sibling declined referrals.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Community-based referrals were provided to the maternal family following the death. Services were declined.

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? No

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)
12/15/2021	Sibling, Male, 17 Years	Mother, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 13 Years	Mother, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 43 Years	Burns / Scalding	Unsubstantiated	

Report Summary:
OCDSS received a report from the SCR alleging that on either 12/14/21 or 12/15/21, the mother locked the subject child and his 17-year-old sibling in a room and they were unable to get out. In the early morning hours of 12/15/21, the home caught on fire. The subject child sustained burns to 90% of his body. The mother died as a result of the fire.

Report Determination: Unfounded | **Date of Determination:** 01/28/2022

Basis for Determination:
OCDSS determined there was no credible evidence the fire was anything other than accidental. Both the mother and subject child died as a result of the fire. The sibling moved out state with the maternal family.

OCFS Review Results:
OCDSS assessed the siblings to be safe with the maternal grandparents. OCDSS interviewed all household members and spoke with CPS in the state where the sibling moved to be with his family. Safety assessments and the RAP were completed accurately and timely. The subject child died during the investigation and OCDSS conducted a review of the facts and circumstances surrounding his death.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
OCDSS missed opportunities to gather information from collateral sources including, law enforcement, fire investigators, and medical personnel with regard to the sibling. The report alleged the mother locked subject child and sibling in their rooms on the night of the fire but information was not gathered from relevant sources to determine the validity of the allegation.

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

Action:
The Syracuse Regional Office informed there is currently an existing PIP in place for this issue as a result of a prior finding by OCFS. OCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/22/2020	Deceased Child, Male, 11 Years	Mother, Female, 41 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 11 Years	Mother, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 16 Years	Mother, Female, 41 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 16 Years	Mother, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
OCDSS received a report from the SCR alleging the mother had an unknown mental health issue and there were concerns for her ability to care for the 11-year-old subject child and 16-year-old sibling. The mother experienced paranoia and delusions while caring for the children. The home was a safety hazard as there was feces and garbage littering the floors.

Report Determination: Unfounded | **Date of Determination:** 04/15/2021

Basis for Determination:
OCDSS determined there was no credible evidence to substantiate the allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter. The investigation was unfounded and closed as the home was observed several times to meet minimal standards. The investigation conclusion narrative stated that the mother "may have untreated MH issues" but refused referrals, thus OCDSS justified unsubstantiating the allegations of Inadequate Guardianship.

OCFS Review Results:
The 7-day safety assessment was not approved in CONNECTIONS until 16 days after receipt of the report as the family was out of the state and OCDSS was unable to assess the safety of the children until the family's return. The safety assessment was completed and documented in CONNECTIONS within 24 hours of the family's return. Information from

a collateral source revealed the maternal grandparents had a court order from out of state indicating they shared joint custody of the children and were to have the children in their care multiple days every week. The record does not reflect that OCDSS contacted the grandparents or the family court in the state where the alleged petitions were filed. The record does not reflect receipt of custody petitions nor communication with CPS in the state despite allegations that there was CPS involvement while the mother and children resided there. Conversations with the mother and children were lacking key safety-related questions, there were no full interviews of the children to assess overall safety and risk. The interviews were allegation based and focused on the conditions of the home. Concerns arose during the investigation related to educational neglect, but the allegation was not added nor substantiated. Concerns for the children's education dated back to 2019, but a legal consultation was not conducted. During two separate conversations, the mother mentioned the landlord planned to set the house on fire and described fire hazards within the home, but the concern was not further addressed, the record did not reflect law enforcement, or the fire department was contacted with regard to the concerns, and the record did not reflect the fire hazards were observed or addressed at any of the multiple home visits.

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:
Conversations with the mother were lacking key safety-related questions; there were no full interviews of the children to assess overall safety and risk. The subject child and sibling were interviewed about allegations only. Neither the subject child nor sibling were asked about the mother's mental health or her concerning behaviors.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
The Syracuse Regional Office informed there is currently an existing PIP in place for this issue as a result of a prior finding by OCFS. OCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Determination of Nature, Extent and Cause of Conditions (Report)
Summary:
Concerns arose during the investigation related to educational neglect, but allegation was not added nor substantiated. On separate occasions, the mother reported concern that the landlord was going to "burn the house down" and reported several fire hazards in the home. OCDSS did not relay the information to law enforcement nor the fire department and there were missed opportunities to document the conditions of the home pertaining to fire safety.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(d)
Action:
The Syracuse Regional Office informed there is currently an existing PIP in place for this issue as a result of a prior finding by OCFS. OCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Review of CPS History
Summary:
The record did not reflect that a review of CPS history was conducted within one business day.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
The Syracuse Regional Office informed there is currently an existing PIP in place for this issue as a result of a prior finding by OCFS. OCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Failure to Offer Appropriate Services

Summary:

The record did not reflect that OCDSS consulted their legal department despite ongoing concerns for the children's educational neglect and the mother's mental health. The record revealed there were multiple closed cases related to the children's education and the mother had not submitted the required homeschooling paperwork for the 2020/2021 school year as of 2/23/21. OCDSS was made aware of the mother's failure to completed the required paperwork on 1/21/21.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

The Syracuse Regional Office informed there is currently an existing PIP in place for this issue as a result of a prior finding by OCFS. OCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/17/2020	Sibling, Male, 16 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 16 Years	Mother, Female, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Male, 12 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 12 Years	Mother, Female, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

OCDSS received a report from the SCR alleging the mother abused methamphetamine to the point of impairment while caring for the subject child and sibling. The mother was paranoid and thought there were men under the house. The mother was unable to care for the children due to her paranoia and substance misuse.

Report Determination: Unfounded | **Date of Determination:** 10/27/2020

Basis for Determination:

OCDSS determined there was no credible evidence to substantiate the allegations. The mother was observed to be sober during each visit, and the children and mother denied substance use. The mother denied that her mental health had a negative impact on her ability to care for the children.

OCFS Review Results:

OCDSS completed case objectives within the required timeframes. OCDSS did not consider the seriousness of the mother's mental health. During a home visit, the mother was having a mental health crisis, hearing voices, exhibiting paranoia, delusions, and disorganized thinking. Collateral sources expressed concern for the mother's mental health and reported the situation was ongoing and impacted her employment and ability to care for the children. OCDSS did not follow up with the mother on whether she sought mental health services and closed the case 40 days after receipt of the report.

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

Issue:

Determination of Nature, Extent and Cause of Conditions (Report)

Summary:

In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. OCDSS observed the mother exhibiting a mental health crisis, hearing voices and paranoia. OCDSS did not appropriately investigate and determine allegations surrounding the mother's mental health.

Legal Reference:

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

Action:

The Syracuse Regional Office informed there is currently an existing PIP in place for this issue as a result of a prior finding by OCFS. OCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Failure to Offer Appropriate Services

Summary:

Caretaking risks were identified for the mother related to her mental health. OCDSS documented the mother's mental health issues yet did not refer her to preventive services because law enforcement did not feel her MH concerns interfered with her parenting skills. OCDSS provided community-based referrals and closed the investigation.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

The Syracuse Regional Office informed there is currently an existing PIP in place for this issue as a result of a prior finding by OCFS. OCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/10/2019	Sibling, Male, 15 Years	Mother, Female, 42 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Male, 15 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 11 Years	Mother, Female, 42 Years	Educational Neglect	Unsubstantiated	
	Deceased Child, Male, 11 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

OCDSS received a report from the SCR alleging the mother had not followed through with any of the requirements for home-schooling the subject child or sibling for the 2019/2020 school year. The mother had not sent in the required reports since the spring of 2019. The mother was aware of the requirements for homeschooling and refused to comply.

Report Determination: Unfounded | **Date of Determination:** 02/07/2020

Basis for Determination:

OCDSS determined the mother was appropriate in supplying the children with their homeschool curriculum and closed their investigation once necessary paperwork to register the children was provided to their respective schools. The investigation was unfounded despite the mother's failure to submit the required paperwork until 1/31/20. OCDSS first became aware of the educational concerns for the children during an initial hotline report on 9/11/19. From 9/11/19 until 1/31/20, the necessary homeschooling paperwork was not completed and the school district informed OCDSS that the children would have a difficult time catching up with work. There was credible evidence to substantiate the case.

OCFS Review Results:

OCDSS completed casework within the required timeframes. There was credible evidence to indicate the allegation of Educational Neglect for both the sibling as well as the subject child as there was no record of the children receiving any education from 9/5/2019 through 1/31/2020; however, OCDSS unfounded Educational Neglect for both children.

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

Issue:

Appropriateness of allegation determination

Summary:
OCDSS justified unsubstantiating the allegation of EdN by stating required paperwork was completed for homeschooling; however, there was no record of the children's education for five months of the 2019/2020 school year as the appropriate paperwork had not been handed in and there was no documentation from the mother that she was following the state curriculum.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
The Syracuse Regional Office informed there is currently an existing PIP in place for this issue as a result of a prior finding by OCFS. OCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/11/2019	Deceased Child, Male, 11 Years	Mother, Female, 41 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Male, 15 Years	Mother, Female, 41 Years	Educational Neglect	Unsubstantiated	

Report Summary:
OCDSS received a report from the SCR alleging the subject child and sibling had a history of not attending school. During the 2018/2019 school year, the sibling was absent 42 days and the subject child was absent 46 days. School started on 9/5/19 and the children had not yet attended. Their absences negatively impacted their educational success.

Report Determination: Unfounded | **Date of Determination:** 09/18/2019

Basis for Determination:
OCDSS determined there was no credible evidence to support the allegations and closed the investigation within 7 days of receipt of report.

OCFS Review Results:
OCDSS unfounded and closed the investigation within 7 days of receipt of the report. Concerns were present related to educational neglect and OCDSS closed their investigation prior to the mother completing the necessary homeschooling paperwork. OCDSS did not stay involved until the paperwork was submitted and the subject child and sibling were enrolled and engaged in a homeschool program despite concerns from the school that there were ongoing concerns dating back to the previous school year regarding the children's failure to attend school and the mother's lack of follow through.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The investigation opened on 9/11/2019 for concerns regarding educational neglect of both the subject child and sibling. OCDSS closed the investigation within 7 days of receipt of the report prior to confirming that the children were enrolled and engaged in their homeschool curriculum.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
The Syracuse Regional Office informed there is currently an existing PIP in place for this issue as a result of a prior finding by OCFS. OCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

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

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

Known CPS History Outside of NYS

OCDSS reached out to CPS intake in another state where the family had previously resided and learned the mother had a CPS history there, though the records had been purged due to time lapse.

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.

Additional Local District Comments

OCDSS does not agree with the citations and have provided specific case facts that were documented in the investigations to support same. Work done by OCDSS to mitigate and address concerns were not recognized. The homeschool requirements were satisfied, and the children were complying at the conclusion of the investigation prior to the fire. Although the mother had mental health issues, she was referred for treatment and there was not a significant negative impact on the children. They were not at risk of foster care placement. The citations outlined in the report are already being addressed in the most recent PIP.

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