Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-22-011

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

Issue Date: Jun 16, 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: 8 year(s)
Jurisdiction: Madison
Gender: Male
Date of Death: 02/27/2022
Initial Date OCFS Notified: 02/27/2022

Presenting Information

Madison County Department of Social Services (MCDSS) received the SCR report on 2/27/22 which alleged that on 2/27/22 around 2:00PM, the grandfather allowed the 7-year-old surviving sibling to operate an adult sized snowmobile and allowed the subject child to ride as a passenger. The grandfather was aware that the children were not wearing helmets while on the snowmobile and failed to take precautions or put safety measures in place to protect the children. As a result, an accident occurred that caused the subject child to be ejected from the snowmobile and become entangled in the track of the snowmobile. Emergency medical services were contacted immediately. The subject child sustained a neck injury while contorted in the track and died at approximately 2:31PM. It was unknown if the children sustained any other physical injuries. The biological mother and biological father had unknown roles.

Executive Summary

This report concerns the death of an 8-year-old subject child that occurred on 2/27/22. MCDSS received a call around 4:08PM from law enforcement informing them of a child fatality and requesting immediate contact. The subject child and two surviving siblings, ages 6 and 5 years old, resided with the paternal grandparents. Another surviving sibling, age 7, resided with the mother and father. The mother, father, and two surviving siblings ages 6 and 5, were not present for the incident.

On the afternoon of 2/27/22 at approximately 2:00PM, the paternal grandfather drove the family snowmobile while the 7-year-old surviving sibling and the 8-year-old subject child rode with him as passengers. Neither child was wearing a helmet. According to New York State law, helmets are not required when riding a snowmobile on the snowmobile owner’s property. It is unknown what caused the subject child to fall from the snowmobile. The paternal grandfather stopped the snowmobile when he smelled the belt burning and noticed the track was not fully on the ground. The subject child’s body was described as “bent in half” within the snowmobile track. A bystander called 911 and law enforcement responded. The subject child was pronounced dead at the scene and was not taken to the emergency room.

MCDSS responded to the scene and safety planned with the family regarding the surviving siblings, who would spend the night with a family resource and then remain with the parents throughout the course of the investigation.

The medical examiner was notified and completed an autopsy. The final autopsy report listed the cause of death was "mechanical asphyxia due to entrapment within mechanism of motor vehicle." The manner of death was accident.

There were no criminal charges or arrests made in relation to this fatality.

MCDSS made several home visits and interviewed the surviving siblings and all adults named in the report. Information was provided to all family members for bereavement services. The mother, children, and grandparents accepted bereavement and/or counseling services. The father declined services.
MCDSS spoke with family members and collateral resources including the source, law enforcement, schools, and the children’s pediatrician.

MCDSS found no preponderance of evidence to substantiate the allegations against the paternal grandfather regarding the death of the child. MCDSS completed all required safety assessments and fatality reports on time.

PIP Requirement

For citations identified in historical cases, MCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) MCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

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:

The fatality report was unfounded. Community-based services were offered to all members of the family to help cope with the death of SC. The record reflects at the time of closing, all family members were engaged in counseling services except BF. No other services were requested by the family.

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

Child Fatality Report

Date of Death: 02/27/2022 **Time of Death:** 02:31 PM (Approximate)

Time of fatal incident, if different than time of death: 02:00 PM

County where fatality incident occurred: Madison
Was 911 or local emergency number called? Yes
Time of Call: 02:27 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
Child's activity at time of incident:

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

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

- ☒ Distracted
- ☐ Absent
- ☐ Asleep
- ☐ Other:

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	8 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	57 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	58 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)
Other Household 1	Mother	No Role	Female	28 Year(s)
Other Household 1	Sibling	Alleged Victim	Female	7 Year(s)

LDSS Response

On 2/27/22, MCDSS received an SCR fatality report and spoke with LE regarding the fatality. LE explained there was a child fatality involving a snowmobile accident. LE explained SC and SS were home with PGF and riding on the snowmobile when SC fell off the back. SC somehow got caught between the track/tread and the body of the snowmobile. LE explained that the fire department had to use tools to get the body out of the tread/track. The SC was pronounced dead at the scene.

On 2/27/22, MCDSS met with BM and BF at the scene and collected information regarding SSs. BF and BM were not

present for the incident. On that same day, MCDSS saw all SSs to assess safety. MCDSS did not observe any injuries to the 7-year-old SS who was present for the accident.

MCDSS reviewed the family's CPS history and obtained a copy of the custody order. At the time of the accident, BM, BF, and PGM shared joint legal custody with primary physical to PGM, however, the 7-year-old SS was residing with the parents while the SC and SSs (aged 6 & 5) were residing with the grandparents.

On 2/28/22, MCDSS interviewed BM, BF, and the 7-year-old SS present at the scene. MCDSS obtained information for collateral contacts and offered counseling services to the family. BM denied any current DV or alcohol use, however, BF had a history with alcohol and no longer drinks alcohol. MCDSS interviewed SS who reported SC was being silly on the snowmobile. SS reported SC was standing up on the back of the snowmobile and PGF would stop until SC sat down. SS did not know SC fell off until she heard him scream. SS reported PGF turned the snowmobile off and PGF and SS attempted to pull SC out from underneath. PGF screamed for help and a bystander called 911. All children denied any drinking and fighting between BF and BM.

MCDSS spoke with LE and reported what SS reported to MCDSS. LE informed MCDSS of witnesses' account that PGF was driving slowly and not acting in a reckless manner. LE reported to MCDSS that helmets are not required on snowmobiles. MCDSS confirmed this information to be true by looking up NYS law.

On 3/4/22, the preliminary autopsy report was received stating the jaws of life were used to remove SC, and death was pronounced on scene. The autopsy reported there were minor blunt force injuries to the head, neck, back and lower legs.

MCDSS interviewed the PGM and PGF. PGF said SS was behind him and SC was in back. They were doing figure eights in the yard, going maybe 5MPH. PGF states he did not even know SC fell off until the snowmobile stopped and smelled like something was burning. PGF reported finding SC after turning the snowmobile off. A lady walking by called 911 and the next-door neighbor came over to help which is when they turned the snowmobile on its side to try to get SC out, but SC was stuck. PGF denied consuming alcohol; LE gave him a field sobriety test that he passed.

On 4/14/22, MCDSS received case information from the DA's office with statements from neighbors, the individual who called 911, firefighters, EMTs, and LE officers.

Multiple home visits were completed, collaterals contacted, bereavement referrals were provided, and the SSs remain with BM and BF. The report was unfounded.

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: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: The record reflects a meeting was held with members of the sheriff's department, child protective services, public health, the police department and community agencies to review the fatality.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060481 - Deceased Child, Male, 8 Year(s)	060503 - Grandparent, Male, 57 Year(s)	DOA / Fatality	Unsubstantiated
060481 - Deceased Child, Male, 8 Year(s)	060503 - Grandparent, Male, 57 Year(s)	Inadequate Guardianship	Unsubstantiated
060481 - Deceased Child, Male, 8 Year(s)	060503 - Grandparent, Male, 57 Year(s)	Internal Injuries	Unsubstantiated
060507 - Sibling, Female, 7 Year(s)	060503 - Grandparent, Male, 57 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:
Bereavement and mental health counseling services were offered. All family members accepted services except BF.

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:
MCDSS assessed the SSs' safety at the aunt's home the day of the fatality. The SSs then remained with the BM and BF throughout the course of the investigation.

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? Yes
Explain:
Bereavement counseling and mental health counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement counseling and mental health counseling. BM, PGF, and PGM participated in services. BF chose to not participate in counseling during the course of the investigation.

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)	Status/Outcome	Compliance Issue(s)
08/28/2021	Sibling, Female, 7 Years	Grandparent, Male, 57 Years	Lack of Supervision	Far-Open	No

Report Summary:
An SCR report alleged PGF left the home and left SS, then age 7, alone and unsupervised. As a result, SS was fearful. SS is not mature enough to be left alone. PGM, BM and SC were listed with unknown roles.

OCFS Review Results:
MCDSS correctly assigned the report to FAR. Contact was made the with source and relevant collaterals. MCDSS engaged the family in developing a Family Led Assessment Guide, completed the 7-day safety assessment, and interviewed all adults and children named on the case. MCDSS consulted with the family when closing the case.

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)
09/16/2020	Deceased Child, Male, 7 Years	Grandparent, Male, 56 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 7 Years	Grandparent, Male, 56 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 7 Years	Grandparent, Male, 56 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 6 Years	Grandparent, Male, 56 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 6 Years	Grandparent, Male, 56 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 6 Years	Grandparent, Male, 56 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 5 Years	Grandparent, Male, 56 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 5 Years	Grandparent, Male, 56 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Grandparent, Male, 56 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Grandparent, Male, 56 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Grandparent, Male, 56 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Grandparent, Male, 56 Years	Lack of Supervision	Unsubstantiated	

Deceased Child, Male, 7 Years	Grandparent, Female, 56 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 7 Years	Grandparent, Female, 56 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 7 Years	Grandparent, Female, 56 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 6 Years	Grandparent, Female, 56 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 6 Years	Grandparent, Female, 56 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 6 Years	Grandparent, Female, 56 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 5 Years	Grandparent, Female, 56 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 5 Years	Grandparent, Female, 56 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 5 Years	Grandparent, Female, 56 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 3 Years	Grandparent, Female, 56 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 3 Years	Grandparent, Female, 56 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 3 Years	Grandparent, Female, 56 Years	Lack of Supervision	Unsubstantiated
Deceased Child, Male, 7 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 6 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 5 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 3 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 7 Years	Father, Male, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 6 Years	Father, Male, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 5 Years	Father, Male, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 3 Years	Father, Male, 30 Years	Inadequate Guardianship	Substantiated

Report Summary:
An SCR report alleged the paternal grandparents' home was unsanitary and unsafe for the SC and the three SSs. The then 6-year-old SS had recently walked home while unsupervised. On 9/21/20 a subsequent report alleged the BF punched the PGF and the PGF swung back at the BF. The SC witnessed the event and screamed and cried which prompted the SSs to do the same. LE responded to the home; the parents threatened and berated a neighbor.

Report Determination: Indicated | **Date of Determination:** 11/24/2020

Basis for Determination:
MCDSS substantiated the allegation of IG against the BF. MCDSS gathered evidence that the BF placed the PGF in a chokehold, which the children witnessed. The children reported feeling scared. MCDSS unsubstantiated the allegations of IG, LS, and IF/C/S against the MGM and PGF, and unsubstantiated IG against the BM as there was no credible evidence. MCDSS assessed the home and concluded it did not pose a risk to the children.

OCFS Review Results:
MCDSS made the right determination in accordance with the evidence gathered. The record did not reflect the source of the subsequent report was contacted. The 7-day safety assessment was not completed and approved within the regulatory timeframe. All children, parents, and grandparents listed on the report were seen and interviewed. The record does not reflect an attempt to contact another adult relative named on the report with no role.

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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
PA was named on the report and there was no documented effort to contact or interview PA.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
MCDSS will make efforts to contact all listed parties on a report.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day safety assessment was completed 9 days late.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-day safety assessment in Connections.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/04/2019	Deceased Child, Male, 6 Years	Grandparent, Female, 54 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 5 Years	Grandparent, Female, 54 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Years	Grandparent, Female, 54 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 2 Years	Grandparent, Female, 54 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 6 Years	Grandparent, Male, 55 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 5 Years	Grandparent, Male, 55 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Years	Grandparent, Male, 55 Years	Inadequate Guardianship	Substantiated	

Sibling, Female, 2 Years	Grandparent, Male, 55 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 6 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 6 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 5 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 5 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 4 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 4 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 2 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 6 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 6 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 5 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 5 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 4 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 4 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 2 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 2 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 26 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Female, 2 Years	Father, Male, 29 Years	Lacerations / Bruises / Welts	Unsubstantiated

Report Summary:
An SCR report alleged ongoing verbal and physical altercations between the BM and BF in the presence of the SC and SSs. The report alleged that the BF beats on the BM and throws things around the home. On 10/3/19, the BF threw a plate at the BM and the plate broke all over and cut the then 2-year-old SS's foot. The report also alleged that the SS had a bruise on her leg and nose from the BF and that the children expressed fear of the BF. Additional allegations included the BM and BF's drug use, the unsanitary condition of the home, and inappropriate activities occurring in front of the children.

Report Determination: Indicated | **Date of Determination:** 12/23/2019

Basis for Determination:
MCDSS substantiated the allegation of IG against the BM, BF, PGM, and PGM regarding all four children. MCDSS gathered evidence that showed ongoing verbal and domestic violence in the home. MCDSS unsubstantiated the allegations of L/B/W and PD/AM. The investigation conclusion does not specify how MCDSS came to this conclusion.

OCFS Review Results:
MCDSS made the right determination to substantiate the allegations of IG. All children, parents, and grandparents listed

on the report were seen and interviewed, however, the record does not reflect adequate attempts to contact another adult relative named on the report with no role. The 7-day safety assessment was completed within regulatory timeframes. MCDSS completed a CPS history check within the same day of receiving the report and contacted the source of the report.

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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
PA was named on the report and there was not sufficient effort to contact or interview PA. PA initiated contact with MCDSS and MCDSS did not return the phone call for one month. The phone call was unsuccessful and the case was closed the day the attempted phone call was made.

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

Action:
The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

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

An SCR report dated 12/14/15 was assigned to FAR with allegations of IG, LS, P/Nx against BM and BF regarding then 1-year-old SS.
An SCR report dated 7/15/16 was assigned to FAR with allegations of IG, L/B/W, P/Nx against BM regarding then 1-year-old SS. A subsequent report was received 9/14/16 with allegations of IG, LS against BM and BF regarding then 2-year-old, 1-year-old SSs and then 3-year-old SC. The report was substantiated for IG against BF.
An SCR report dated 10/10/17 was substantiated against BF for the allegations of IG regarding all children in the household and unsubstantiated against BM, PA, PGM, and PGF.
An SCR report dated 9/1/18 was unsubstantiated for allegations of IFCS, XCP, IG against BM and BF.
An SCR report dated 1/24/19 was unsubstantiated for allegations of IG against BF.

Known CPS History Outside of NYS

No known history outside 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