Child Fatality Report

Report Identification Number: AL-18-014

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

Issue Date: Dec 12, 2018

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		

Case Information

Report Type: Child Deceased
Age: 28 day(s)
Jurisdiction: Columbia
Gender: Female
Date of Death: 06/22/2018
Initial Date OCFS Notified: 06/22/2018

Presenting Information

An SCR report alleged on 6/22/18, the 28-day-old SC was in the care of her mother (SM) when she became unresponsive. SC died after going into cardiac arrest and suffered respiratory failure. SM was inconsistent with the explanation of how the child became unresponsive. SC was an otherwise healthy child. The home of the SM was a health and safety hazard for SC and the 3 surviving siblings (SS). SM was a hoarder and the home was cluttered, messy and dirty. There was not adequate space for the children to move around. SM was aware and failed to adequately intervene.

Executive Summary

Columbia County Department of Social Services (CCDSS) received a report from the SCR on 6/22/18, concerning the death of the 28-day-old female SC. There was an open investigation received on the same date, regarding the incident that lead to SC's death, as well as concerns for drug use, supervision concerns and unsafe home conditions.

Through a joint investigation with LE, it was learned SC became unresponsive after SM fed her a bottle. SM called 911 and SC was transported via ambulance to Columbia Memorial Hospital where life saving measures were performed. SC was unable to be revived and she passed away at 4:39 PM. The 4yo sibling was home at the time of the incident and the 13 and 7yo siblings were at school.

An autopsy was performed and the coroner's report determined SC's cause of death was an "apparent hypoxic event/found unresponsive next to mother when mother awakened." Other significant conditions listed were "prematurity and bronchopneumonia" and "trace amounts of fentanyl in the child's system; not enough to cause death." LE closed their investigation with no charges filed.

Through a review of CPS history, it was learned SM and BF had a history of drug abuse and DV incidents. There were no recent reported incidents of DV and SM was actively engaged in a drug treatment program, which included mental health counseling and medication management. SM denied taking any nonprescribed substances on the day of the incident and her drug screen completed on 6/23/18 was positive for prescribed substances only. Throughout the investigation, CCDSS assessed the safety of the 3 siblings, which were deemed safe in SM's care.

BF had regular visitation with the children, although had only seen SC once since birth. His home was assessed to be safe for the children and he expressed no concerns for SM's care of the children. BF was on probation due a drug offense in July 2017. He completed a drug screen, which was negative, and there were no recent concerns for drug use. Bereavement and counseling services were offered to BF, although he declined.

CCDSS thoroughly investigated the incident and substantiated the allegations of Inadequate Guardianship and DOA/Fatality, as EMS records showed SM left SC unattended for a period of 20 minutes after feeding her. SC aspirated on vomit, her airway was blocked and she did not have a pulse upon arrival of EMS. During autopsy, it was determined SC had Fentanyl in her system and the source of the drug and how it got into SC's system was unable to be determined. SC was in the care of SM during the timeframe she was exposed to the drug. Prior to SC's death, there were several incidents reported of SM not properly supervising the 4yo sibling around SC and SM appearing disheveled and "dozing" during medical appointments. The allegation of inadequate food, clothing, shelter was unsubstantiated, as there were no safety hazards observed in the home and SM made improvements on the cluttered condition throughout the investigation.

A Preventive Services case opened to monitor SM's engagement in treatment, assist SM in obtaining MH counseling for the children, address educational concerns for the 13yo sibling and to assist in organizing the home. SM continued receiving MH counseling through her treatment provider and funeral assistance was provided to the family.

PIP Requirement

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:

Casework activity was commensurate with case circumstances and the allegations were appropriately determined.

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:

The case was appropriately opened for Preventive Services.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment

Summary:	Although safety of the siblings was adequately assessed within the required timeframe, the 7-day safety assessment was not completed in Connections.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	CCDSS will complete all safety assessments in Connections within the required timeframe. The Albany Regional Office noted they are aware of this issue, as there is a current PIP in place for this citation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/22/2018 **Time of Death:** 04:39 PM

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

County where fatality incident occurred: Columbia
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? Yes
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 supervisor was: Not impaired.

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	Female	28 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	7 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	13 Year(s)
Other Household 1	Father	No Role	Male	41 Year(s)

LDSS Response

CCDSS initiated their investigation within 24 hours of receipt of the report. They spoke to the source, reviewed CPS history and assessed the safety of the MGP's home, where SM and the 13yo sibling were staying temporarily. BF's home was assessed for safety on 6/23/18 by Greene County Department of Social Services, as the 7 and 4yo siblings stayed with him temporarily. BF had no concerns for SM's care of the children.

CCDSS referred both parents for mobile crisis services, as well as drug screens, due to both having a history of heroin abuse. When SM and the children returned to their home on 6/28/18, the home was assessed for safety. Although it was observed to be cluttered with belongings, there were no drugs observed or safety hazards identified.

Joint interviews were conducted with LE and CCDSS. SM reported SC was born 1 month prematurely, although was healthy and on the morning of the incident, SC appeared alert and was acting normal. The 13 and 7yo siblings went to school, then SM attended a 9:00 AM treatment appointment with the 4yo sibling and SC. While at the appointment, a woman held SC, then on the way home the cab driver watched SC for a few minutes while she and the 4yo went into a store. They arrived home around 10:30 AM and SM sat next to the 4yo sibling on the couch, held SC and fed her 2 ounces of formula. SM reported to EMS that she fed SC, then laid her down on the living room couch to rest and left the room for approximately 20 minutes, finding SC unresponsive upon her return. Further details were not reported regarding what position she placed SC in, what position she was in when found, or what other items were on the couch. SM contradicted her statement to EMS and reported to CCDSS she continued to hold SC in her arms after feeding her and never laid her down. A few minutes later she noticed SC was blue and not breathing. SM took SC next door for help and returned home when the neighbor did not answer the door. She attempted to blow air into SC's mouth and SC began to vomit and it came out of her nose and mouth. SM called MGM, then called 911 and followed instructions for CPR. The neighbor and EMS arrived and performed CPR. SC was transported to the hospital, where SM was informed SC was not going to recover and she passed in SM's arms. SM was unaware how Fentanyl got into SC's system and denied having access to the drug.

CCDSS regularly assessed the safety of the siblings throughout the case and monitored the condition of the home. The children reported no concerns for SM using drugs or for her care of them. The 4yo sibling did not provide any details about the incident, due to limited verbal skills.

CCDSS conducted a thorough investigation and obtained records from numerous collaterals, including EMS, hospital, pediatrician, school and LE and spoke to SM's substance abuse treatment counselor, the property manager at SM's building and several neighbors and family members.

EMS reported upon their arrival SC had no pulse, had aspirated on vomit and her airway was blocked. Hospital records showed SC had no pulse upon arrival and was hypothermic with a temperature of 89.4 degrees Fahrenheit. SC regained a pulse for a short time, although was not able to be stabilized. The children's pediatrician reported several incidents prior to SC's death of SM arriving disheveled, exhausted and was "dozing" in the waiting room and not properly supervising the children. SM's treatment records showed SM was compliant with treatment and medication management. SM was drug screened regularly, although Fentanyl was not part of the drug panel, and there were no recent concerns for substance misuse. The counselor felt SM was falling asleep due to being tired from caring for the children or she was displaying side effects from her prescribed medication.

CCDSS appropriately indicated the case and at the time of this writing, the family had begun to engage in Preventive Services.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From an injury - external cause

Person Declaring Official Manner and Cause of Death: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048448 - Deceased Child, Female, 28 Days	048449 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
048448 - Deceased Child, Female, 28 Days	048449 - Mother, Female, 37 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
048448 - Deceased Child, Female, 28 Days	048449 - Mother, Female, 37 Year(s)	DOA / Fatality	Substantiated
048450 - Sibling, Male, 13 Year(s)	048449 - Mother, Female, 37 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
048450 - Sibling, Male, 13 Year(s)	048449 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
048451 - Sibling, Female, 7 Year(s)	048449 - Mother, Female, 37 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
048451 - Sibling, Female, 7 Year(s)	048449 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
048452 - Sibling, Male, 4 Year(s)	048449 - Mother, Female, 37 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
048452 - Sibling, Male, 4 Year(s)	048449 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐

Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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: Although safety of the SS was assessed within the required timeframe, a 7-day safety assessment was not completed in Connections.				

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:
Service needs were accurately identified for the family and a Preventive Services case was opened.

Placement Activities in Response to the Fatality Investigation

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

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☒	☐	☐	☐	☐	☐	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☒	☐	☐	☐	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☒	☐	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☒	☐	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☒	☐	☐	☐	☐	☐	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐

Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The children were referred for MH counseling and SM was in the process of obtaining this service.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SM was referred for crisis services and received funeral assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? 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

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)
06/22/2018	Deceased Child, Female, 28 Days	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Sibling, Male, 13 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

Sibling, Male, 4 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 4 Years	Mother, Female, 37 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 28 Days	Mother, Female, 37 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 13 Years	Mother, Female, 37 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 7 Years	Mother, Female, 37 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 4 Years	Mother, Female, 37 Years	Lack of Supervision	Substantiated
Deceased Child, Female, 28 Days	Mother, Female, 37 Years	Lack of Supervision	Substantiated

Report Summary:
An SCR report alleged on 6/22/18, SM was feeding SC when she didn't look right and went into cardiac arrest. There were numerous stories to what happened to the child and SM was saying very little about the incident. SM appeared to be in an altered state as she may have been impaired on drugs. SC was blue on the scene and arrived in the hospital grayish. Two subsequent reports were received on 6/22/18 and were merged with additional concerns for drug misuse, supervision and the condition of the home.

Report Determination: Indicated | **Date of Determination:** 10/09/2018

Basis for Determination:
It was determined SM was often disheveled and "dozing" while at medical appointments with SC and 4yo SS. On 6/22/18, SM found SC unresponsive and called 911. The EMS report stated SM laid SC down on the couch after feeding her and noticed she was blue and unresponsive 20 minutes later, although SM denied leaving SC unattended. SM denied using any drugs. SC passed away and the autopsy report listed the cause of death as "apparent hypoxic event/found unresponsive next to mother when mother awakened." The report further showed trace amounts of Fentanyl were found in SC's system and the source was not determined.

OCFS Review Results:
CCDSS conducted a thorough investigation of the allegations and made referrals from the family for community-based services and Preventive Services. The case was appropriately opened for Preventive Services.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/08/2018	Deceased Child, Female, 14 Days	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Far-Closed	No
	Sibling, Male, 4 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 7 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 13 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
An SCR report alleged on an ongoing basis, SM used an unknown substance while the sole caretaker of the children. SM

became intoxicated and was unable to care for the children. The last known incident was 6/8/18 when SM was "nodding out" while holding SC.

OCFS Review Results:
CCDSS completed the 7-day Safety Assessment accurately and on time and the case was appropriately deemed FAR eligible. The required notices of FAR receipt and FAR closure were provided to the parents. Necessary collateral contacts were made and SM was referred for drug testing. Safe sleep education was provided and a safe sleep environment was observed and appropriate supervision of the children was discussed. A new SCR report was received on 6/22/18 regarding the incident that lead to SC's death. BF was interviewed and the children's safety was assessed prior to case closure. The case closed on 7/10/18 and the allegations were appropriately addressed in the subsequent investigation.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/24/2015	Sibling, Male, 10 Years	Father, Male, 38 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 10 Years	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 4 Years	Father, Male, 38 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 4 Years	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 2 Years	Father, Male, 38 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 2 Years	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged SM and BF had a serious history of DV. A few days prior, BF beat SM in the presence of the children and SM sustained injuries on her arm. BF was abusing heroin in the presence of the children, got high, and became violent with SM. SM was afraid of him.

Report Determination: Unfounded | **Date of Determination:** 01/29/2016

Basis for Determination:
The parents had a history of verbal and physical altercations and SM's treatment provider expressed concerns for DV, although all family members denied any current concerns and SM denied the bruise on her arm was inflicted. SM was engaged in a drug treatment program and yielded negative drug screens. CCDSS referred BF for a drug screen and he tested positive for heroin. BF did not reside in the home and it was determined BF was never the sole caretaker for the children.

OCFS Review Results:
CCDSS completed a thorough investigation and made appropriate collateral contacts and referrals for drug screens. CCDSS assessed the safety of the children and home throughout the investigation and they were deemed safe in SM's care. Preventive Services were appropriately offered and SM declined. SM remained engaged in substance abuse treatment, which included MH counseling and medication management, and the provider was aware of the concerns for DV.

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

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

SCR report 10/20/11 was substantiated for the allegation of IG against BF and unsubstantiated for the allegation of IG against SM regarding the 13 and 7yo SS. BF assaulted SM in the presence of the children. SM obtained a stay away OP in Family Court against BF, applied for custody of the children and she attended DV counseling.

SCR report 11/10/10 was unsubstantiated for the allegations of IG against SM and BF regarding the 13yo SS. A verbal

argument took place between SM and BF, although SS was in a bedroom with the door shut. BF was arrested for violating a previous OP that he refrain from harassing SM. BF completed an anger management group.

Known CPS History Outside of NYS

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

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No