Child Fatality Report

Report Identification Number: RO-19-014

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

Issue Date: Sep 27, 2019

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: 5 month(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 04/17/2019
Initial Date OCFS Notified: 04/17/2019

Presenting Information

Two SCR reports were received regarding the five-month-old infant's death. The first report alleged the father gave the infant a bath, then placed him on a bed and stepped out of the room to get a diaper. When the father returned to the room, the infant was face down on the bed and unresponsive. The father and paternal grandmother were caring for the infant and were unable to provided a plausible explanation for his death. The second report alleged the father placed the infant in a portable crib for a nap. He checked on the infant at approximately 11:29 AM, and found the infant had rolled over and suffocated face-down on a blanket. The father called 911 and first responders administered CPR, but were unable to revive him. The infant was pronounced deceased at the hospital at 12:23 PM.

Executive Summary

On 4/17/19, the Monroe County Department of Human Services (MCDHS) received an SCR report regarding the death of the five-month-old male infant. The infant resided with his mother, father, paternal grandmother, three-year-old sibling and mother's other two children, aged 12 and 10. At the time of the incident, the father's other two children, aged 10 and 8, were visiting the home, the mother was at work, and the paternal grandmother had just arrived home.

Through a joint investigation with law enforcement, it was learned on 4/17/19, the father checked on the infant, who was sleeping in his portable crib. He discovered the infant was face-down with a blanket wrapped around his head and he was unresponsive. The father called 911 and followed instructions for CPR until first responders arrived. The infant was transported to Rochester General Hospital via ambulance, where life-saving measures continued. The infant was pronounced deceased at 12:23 PM by the emergency room physician.

An autopsy was performed and the results were pending further investigation. The law enforcement investigation was listed as a non-criminal incident pending the results of the final autopsy report.

The home was assessed to contain no safety hazards for the siblings and there were no concerns gathered for the children's safety in their parents' care. The infant's portable crib was found to have several blankets and a dip in the bassinet area which the father said was from tucking the sheet tightly under the mattress. MCDHS referred the family to a trauma intervention program, mental health services, grief support groups and provided burial assistance.

The allegation of DOA/Fatality against the father and paternal grandmother and Inadequate guardianship against the paternal grandmother were appropriately unsubstantiated. There was a lack of credible evidence gathered that the father's actions caused the infant's death and the grandmother was not caring for the infant at the time of his death. The allegation of Inadequate Guardianship was appropriately substantiated against the father since he placed the infant in immediate danger of harm by utilizing an unsafe sleep environment, despite knowledge of safe sleep guidelines.

The allegation of Parents Drug/Alcohol Misuse was added and substantiated against the paternal grandmother regarding the three oldest siblings. On 6/10/19, the grandmother became intoxicated, allegedly took some pills that were not prescribed to her, and began cursing at and belittling the three children. The eight-year-old and three-year-old siblings were not present for the incident. As a result of the incident the family moved out of the home and went to Ontario County, where they were provided with emergency housing assistance and a Family Services Intake was opened. At the time this report was written, a housing specialist in Ontario County was assisting the family with obtaining permanent housing and MCDHS had closed their case.

PIP Requirement

For issues identified in a historical case, Otsego County DSS will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify action(s) Otsego County has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, Otsego County 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:

The case was appropriately closed in Monroe County and a Family Services Intake was opened in Ontario County to provide housing assistance.

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 case was thoroughly investigated and there was documentation of supervisory consultation.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 04/17/2019 **Time of Death:** 12:23 PM

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

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 11:30 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 1 Hours
At time of incident 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	Male	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	31 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	59 Year(s)
Deceased Child's Household	Mother	No Role	Female	28 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	10 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Other Household 1	Other Adult - Sibling's Mother	No Role	Female	29 Year(s)
Other Household 1	Sibling	Alleged Victim	Male	10 Year(s)
Other Household 1	Sibling	No Role	Female	8 Year(s)

LDSS Response

Within 24 hours of receiving the SCR report, MCDHS searched SCR history, listened to the 911 call and reviewed the records from the hospital, EMS, and law enforcement. They assessed the home and spoke to the five siblings, the father, paternal grandmother and the biological mother of the father's 10 and 8-year-old children. MCDHS went to the hospital and spoke to the mother and hospital staff. Safety assessments were completed accurately and timely.

Joint interviews were conducted by MCDHS and law enforcement. It was learned the infant was healthy, developmentally on target, and he recently started to rollover. The parents said they were educated about safe sleep and they always placed the infant to sleep in the portable crib.

On the morning of 4/17/19, the mother was at work, the grandmother left the home for a few hours and the father was caring for the six children. The father laid the infant on his back in his portable crib with multiple blankets. He propped a bottle, as they always did, using a blanket formed in a u-shape to surround the bottle. While the infant was eating, the father went to give the three-year-old sibling breakfast and a bath. About an hour later, the father went to check on the infant and change his diaper. He observed the infant face-down on his stomach and a blanket was wrapped around his head. When he rolled the infant over his face was pale and his body was limp. The father brought the infant into the living room and called 911. The father called the mother around 11:45 AM and stated that the infant could not breathe. The ambulance was at the home when the mother arrived, and she followed it to the hospital. The parents admitted to occasional marijuana use, although denied using while caring for the children. The father denied using drugs on the day of the incident.

The paternal grandmother arrived home while the infant was sleeping in the crib and she had not seen the infant since the night prior. She had no concerns for the parents' care of the children. The children all reported being in the living room of the home when the father found the infant not breathing in his crib. They reported no concerns regarding their care. The biological mother of the father's two children reported no concerns for her children. Reasonable attempts were made to locate and speak to the biological fathers of the mother's two children and were unsuccessful.

MCDHS contacted all necessary collaterals. Hospital records showed the infant arrived in cardiac arrest and there were no signs of trauma. The children's pediatrician had no concerns for their care. The 911 call and the officer's body camera video were consistent with the father's explanation of the incident.

MCDHS thoroughly investigated the fatal incident, as well as the incident that occurred during the investigation with the paternal grandmother. They assessed the ongoing safety of the children and referred the family for the appropriate services. MCDHS appropriately consulted their legal department and closed the case, as the family was receiving services in Ontario County.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051309 - Deceased Child, Male, 5 Mons	051310 - Father, Male, 31 Year(s)	DOA / Fatality	Unsubstantiated

051309 - Deceased Child, Male, 5 Mons	051310 - Father, Male, 31 Year(s)	Inadequate Guardianship	Substantiated
051309 - Deceased Child, Male, 5 Mons	051317 - Grandparent, Female, 59 Year(s)	DOA / Fatality	Unsubstantiated
051309 - Deceased Child, Male, 5 Mons	051317 - Grandparent, Female, 59 Year(s)	Inadequate Guardianship	Unsubstantiated
051309 - Deceased Child, Male, 5 Mons	051310 - Father, Male, 31 Year(s)	Lack of Supervision	Unsubstantiated
051313 - Sibling, Female, 10 Year(s)	051317 - Grandparent, Female, 59 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
051314 - Sibling, Male, 12 Year(s)	051317 - Grandparent, Female, 59 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
051316 - Sibling, Male, 10 Year(s)	051317 - Grandparent, Female, 59 Year(s)	Parents Drug / Alcohol Misuse	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?	☒	☐	☐	☐

Additional information:

Reasonable attempts were made to locate and interview the biological fathers of the mother's 12 and 10-year-old children, but were unsuccessful.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				

Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The family received housing assistance when they became homeless in Ontario County and they were referred for mental heath counseling and grief 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?	☐	☒	☐	☐

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 trauma services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were referred for trauma services, mental health services and grief support groups.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No

Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/17/2016	Sibling, Male, 9 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 9 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 7 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 7 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 1 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 1 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report received by Otsego County Department of Social Services alleged on 9/16/16, the father left the three siblings, aged nine, seven and one-year-old at the time, unsupervised for at least an hour. When LE arrived at the home, the two older children were asleep and the youngest was standing up in a stroller crying. The father did not make a plan for the children to be watched, therefore the children were at risk of harm.

Report Determination: Indicated **Date of Determination:** 03/08/2017

Basis for Determination:
The mother was working the overnight shift when the father left the three children home alone. LE were called to the home when the youngest sibling was heard crying for a long time. The father was intoxicated when he returned home 45 minutes later and he was charged with three counts of Endangering the Welfare of a Child. The parents agreed not to leave the children unsupervised and not to consume alcohol while the sole caretaker for the children. The parents reported it was an isolated incident. The father was ordered by criminal court to complete an alcohol evaluation and engage in parenting classes. The children appeared to be safe and the case was closed.

OCFS Review Results:
The biological father of the sibling was listed on the SCR report as "unknown". Otsego County incorrectly determined he was reported in error due to the mother not having contact information and reporting he did not have contact with the child. Reasonable efforts should have been made to locate the two fathers of the mother's two oldest children in order to provide Notice of Existence letters and speak to them about the report. Several progress notes were entered more than

five months after the event date. Referrals were appropriately made for Addiction Recovery Services and Preventive Services and the parents were advised of possible Family Court action if another incident occurred.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Several progress notes were entered more than five months after the event date.
Legal Reference:
18 NYCRR 428.5
Action:
All progress notes will be entered as contemporaneously as possible to their event dates.
PIP Requirement:
Otsego County Department of Social Services will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify action(s) Otsego County has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, Otsego County will review the plan and revise as needed to address ongoing concerns.

Issue:
Failure to provide notice of report
Summary:
The biological father of the sibling was listed on the SCR report as "unknown" and Otsego County Department of Social Services incorrectly determined he was Reported in Error. The biological fathers of the mother's two oldest children should have been added to the report and reasonable efforts should have been made to locate them and to provide them with Notice of Existence letters.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
Otsego County Department of Social Services will make reasonable efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.
PIP Requirement:
Otsego County Department of Social Services will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify action(s) Otsego County has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, Otsego County will review the plan and revise as needed to address ongoing concerns.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
Otsego County Department of Social Services did not make reasonable efforts to interview the two biological fathers of the mother's two oldest children about the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children and other persons named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.
PIP Requirement:

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

[redacted]

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

An SCR report received by MCDHS on 3/16/14, was unsubstantiated for the allegations of Inadequate Food, Clothing, Shelter, Parent's Drug/Alcohol Misuse and Inadequate Guardianship against the mother regarding her two oldest children.

An SCR report received by Orleans County Department of Social Services on 8/28/15, was unsubstantiated for the allegations of Lack of Medical Care and Inadequate Guardianship against the mother regarding the youngest sibling.

Known CPS History Outside of NYS

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

Preventive Services History

A Family Services Intake (FSI) was opened in Otsego County on 6/1/17, after the father failed to complete an alcohol evaluation and parenting classes, as ordered by criminal court. An Article 10 Neglect Petition was filed in Otsego County Family Court and the father failed to show for two appearances, resulting in a warrant being issued for his arrest. The family relocated and the FSI was closed on 8/19/17, when efforts to locate the family were unsuccessful.

An FSI was opened in Otsego County on 9/6/17, when the family was located in Monroe County. OCDSS requested that Monroe County make contact with the family and documented that they intended to obtain an Order of Supervision and transfer the court order to Monroe County Family Court. A Family Services Stage was opened on 9/20/17. Monroe County spoke to the father on the phone and he refused to cooperate, would not allow the children to be seen at school, and he threatened to sue the county. Otsego County advised their Family Court Judge that the family had moved to Monroe County and that the father was not being compliant. The petition was withdrawn and the services case was closed on 5/4/18.

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