Child Fatality Report

Report Identification Number: SV-17-014

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

Issue Date: Sep 22, 2017

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		
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
CPR-Cardiopulmonary Resuscitation		
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

Case Information

Report Type: Child Deceased
Age: 2 month(s)

Jurisdiction: Sullivan
Gender: Male

Date of Death: 05/19/2017
Initial Date OCFS Notified: 05/19/2017

Presenting Information

On 5/19/2017 an SCR report was received by Sullivan County Division of Family Services (SCDFS) regarding the death of the 2-month-old SC. The report alleged the SC passed away while under the care and supervision of the SM. The morning of 05/19/17, at approximately 9:30 am, the SM observed the SC, and he was alive and well. Later on in the morning, at approximately 11:27 am, the SM found the SC in his pack and play, lying on his back deceased. There was a pillow in the pack and play with the SC. There was no explanation for the SC's death. The SC was previously seen and treated for minor ailments, however, these ailments did not contribute to his death. The house was messy and in disarray. There was food strewn all over posing a sanitary concern for the SC and his 20-month-old SS. The BF of the SC had an unknown role.

Executive Summary

This report concerns the death of the 2-month-old SC. The SC was part of an open Preventive Services case and an ongoing CPS Investigation at the time of the fatality. Additionally, an SCR report was also received on 5/19/17 concerning his death. The SCR report alleged that the physical conditions in the home of the SM were unhealthy and posed a hazard to the SC and the 20-month-old SS. The report also mentioned the SC was found deceased in the bassinet, lying on his back with his head on a pillow. Upon finding the SC deceased, the SM called her service worker and was told to call 911. EMS responded to the home and the SC was pronounced dead. LE were also at the home of the SM and secured the home as a possible crime scene. SCDFS and LE jointly investigated the death of the SC.

In June of 2016, the SM requested assistance from SCDFS regarding support and education in caring for the SS. At that time the Preventive Services case was opened. The SM had been working with an outside service provider contracted by SCDFS Preventive Services, in addition to local prevention services district staff at the time of the fatality.

On the day of the fatal incident, the SM made arrangements for the SS to stay with a friend until the she returned home and could care for her. SCDFS located and made contact with both the SS and the adult who was caring for her. The SS and the friend's home were assessed and found to be safe. A few days into the investigation, it was determined that the SM suffered from diagnosed and untreated mental health issues and was using illicit drugs. There were also concerns the SC and SS had not received necessary medication and medical treatment under the care of the SM. The SS was removed from the care of the SM and a neglect petition was filed in Family Court. The SS went to stay with another friend of the SM's as an Article 10 direct placement. The SM had 3 children previously removed from her care in 2011 and 2012, and an Article 10 neglect petition was filed against the SM and BF. The SM had no contact with these children.

At the time of this fatality report, LE continued to investigate the death of the SC, and had intentions of interviewing the SM again. LE had not yet pursued criminal charges, but had not been ruled out. The ME performed an autopsy and the final report showed manner and cause of death were undetermined. When referring to the cause of death the ME noted the SC was found in a bassinet with pillows. It was noted the SC's body showed no signs of abuse or trauma and the toxicology tests showed nothing of suspicion.

SCDFS made the appropriate decision to substantiate the allegations in the investigation. There was evidence the SM was not taking medication for her MH diagnosis and as a result was struggling with caring for the SC and SS. SCDFS also documented the SM was not giving the SC or SS prescribed medication and she was failing to bring them to follow up pediatrician appointments. SCDFS concluded the circumstances further enhanced the vulnerability of the SC and due to the SM's poor judgment, the SC was harmed. The BF was not allowed contact with the SC at the time of his death, due to an active OP.

SCDFS provided ongoing support to the SM following the fatality. SCDFS referred the SM for a substance abuse evaluation and MH treatment. The welfare of the SM was an ongoing concern for SCDFS and they made continued contact throughout the investigation. SCDFS offered the SM assistance in finding new housing and the final arrangements for the SC. SCDFS also provided the BF of the SC information on grief counseling services.

For the citations that follow, SCDFS will submit a PIP to the Regional Office within 30 days of receipt of this report. This PIP will identify what actions the local district has taken, or will take, to address the cited issues. For citations where a PIP is currently implemented, SCDFS will review the plans and revise as needed to further address on-going concern.

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? 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:
It was appropriate for SCDFS to close the investigation. There was an open Preventive Services Case at the time of the fatality. The case changed to a foster care case after the fatality as the result of the removal of the SS and CPS had a monitoring role.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/19/2017 **Time of Death:** Unknown

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

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

- [x] 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 **Is the caretaker listed in the Household Composition?** Yes - Caregiver 1 **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	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	20 Month(s)
Other Household 1	Father	No Role	Male	28 Year(s)

LDSS Response

On 5/19/17 SCDFS received an SCR report and promptly began an investigation into the death of the SC. SCDFS reviewed CPS history and contacted the source, service providers and LE. The DA had already notified the ME about the fatality. Throughout the investigation SCDFS contacted the nurse working with the SC, the ME, friends of the SM, first responders and childcare providers for the SC and SS. The SM signed releases for SCDFS and they also reviewed prescription, medical, and MH records for the SM, SC and SS.
SCDFS went to the home of the SM and were not permitted inside because the police were still at the scene gathering evidence. The SM's friend was at the home gathering belongings for the SS. SCDFS learned a plan had been made for the friend to care for the SS until the SM returned home. SCDFS went to the friend's home and saw the SS; the home and child were deemed safe. SCDFS then went with LE to the police department where an investigator from the DA's office was interviewing the SM. SCDFS met with the SM after LE interviewed her and asked her to make a safety plan for the SS. The SM offered a family friend as a resource and later broke the safety plan. The SS was then removed and SCDFS filed a neglect petition against the SM due to concerns of lack of medical treatment for the SC and SS. The SS was placed with the SM's

friend through Article 10. SCDFS also found evidence the SM was using illicit drugs through a drug screening. The SM was offered MH and substance abuse services.

SCDFS gathered information about the time leading up to the fatality from the SM's community service provider (an agency contracted by SCDFS). The service provider stated at about 11:25 am on 5/19/17, the SM called her very upset, and reported the SC was not moving and she wanted the worker to come to her home. The worker advised the SM to hang up and call 911. The SM was distraught and the worker reported telling her 3 times to call 911 before the SM ended the call. The worker headed to the apartment and found EMS, LE and the Coroner were already there and SC had been pronounced dead. The worker observed the SC to be dressed only in a diaper and rigor mortis had started.

There was no clear timeline in the case documentation regarding the events leading up to the SC's death. While it was noted that LE interviewed the SM for several hours, the SM's statement was not noted in Connections. The SM told the services worker the SC slept in his bassinet in his room the night before his death. The SM reported she woke up earlier that morning and went to boil water for coffee. The SS was awake and in the kitchen with the SM. The SM checked on the SC at about 10:25AM and he was fine. That was the last time he was seen alive. Photographs taken of the home on the day of the fatality showed the SC lying on his back, on the top section of a pack and play. The SC was wearing only a diaper and his head was propped on a pillow, with a "pillow roll" under it. Underneath the SC was a "worn onsie" and an infant sock. Surrounding the SC in the bassinet were 2 pacifiers a stuffed animal.

The SM was questioned about the SC's medical care and SCDFS discovered the SC was not being given medication he was prescribed on 5/1/17 to treat an acute illness. SCDFS noted the SM missed several follow up appointments for the SC. SCDFS also discovered the SS was not receiving prescribed medication while under the SM's care. There was also concern about the SC being exposed to second hand smoke.

SCDFS discovered the SM was not taking her medication as prescribed and was also buying and consuming illicit drugs. It was not clear SCDFS questioned the SM about her knowledge of safe sleep, but numerous collaterals reported previously providing her with information.

The BF was interviewed and SCDFS found that he had no information regarding the death because he was not present in the home.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical 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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
038241 - Deceased Child, Male, 2 Mons	038243 - Mother, Female, 27 Year(s)	Lack of Medical Care	Substantiated

038241 - Deceased Child, Male, 2 Mons	038243 - Mother, Female, 27 Year(s)	Lack of Supervision	Substantiated
038241 - Deceased Child, Male, 2 Mons	038243 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
038241 - Deceased Child, Male, 2 Mons	038243 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated
038242 - Sibling, Female, 20 Month(s)	038243 - Mother, Female, 27 Year(s)	Lack of Medical Care	Substantiated
038242 - Sibling, Female, 20 Month(s)	038243 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
038242 - Sibling, Female, 20 Month(s)	038243 - Mother, Female, 27 Year(s)	Lack of Supervision	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 safety 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				

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
SCDSS initially worked with the SM and made a safety plan requiring the SS to stay with a family friend. The SM identified this individual and was in agreement with the plan. Several days later, the SM was no longer willing to have the SS stay with the friend and a removal was necessary.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒ Family Court ☐ Criminal Court ☒ Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	038243 Mother Female 27 Year(s)	
Comments:	The SS entered foster care on 5/22/17 after SCDSS did a removal under Article 10 Section 1024 of the Family Court Act. On 5/24/17 the SM requested and received a 1028 hearing and agreed to the direct placement of the SS with a friend. On 7/14/17 the friend decided she could no longer care for the SS and the SS was again placed in foster care. There is no information in the case record that an Article 10 neglect petition was filed by SCDSS, but there had to have been for the matter to be in Family Court.	

Have any Orders of Protection been issued? Yes	
From: 05/24/2017	**To:** Unknown
Explain: An stay away Order of Protection was issued by The Family Court Judge against the SM in regard to the SS. The order was later changed to a supervision order.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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							

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? Yes
Was the child acutely ill during the two weeks before death? Yes

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

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)
05/16/2017	Sibling, Female, 22 Months	Mother, Female, 27 Years	Inadequate Guardianship	Indicated	No
	Deceased Child, Male, 3 Months	Father, Male, 28 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 22 Months	Father, Male, 28 Years	Inadequate Guardianship	Indicated	

	Deceased Child, Male, 3 Months	Mother, Female, 27 Years	Inadequate Guardianship	Indicated	

Report Summary:
An SCR report was received stating that the SM and BF of the SC engaged in a physical and verbal altercation with the SC and the SS present in the home. The SM and BF were physically assaulting each other and the police were contacted and did respond. The report was a subsequent and was not merged with the SCR report made on 4/20/2017.

Determination: Indicated | **Date of Determination:** 07/13/2017

Basis for Determination:
The SM was aware of the BF's violent history yet continued to have contact with him and allowed him to be alone with the children. The SM requested and received an Order of Protection against the BF for herself, the SS and SC. During a home visit the BF of the SC was found to be alone with the SC and the SS, despite the order of protection.

OCFS Review Results:
The SC passed away 3 days after the report was received. SCDFS did appropriately address the allegations in the report, but entered all pertinent case notes into the previous investigation dated 4/20/17.

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)
04/20/2017	Deceased Child, Male, 2 Months	Mother, Female, 27 Years	Lack of Medical Care	Indicated	Yes
	Deceased Child, Male, 2 Months	Mother, Female, 27 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Indicated	

Report Summary:
An SCR report was received that alleged the SM had MH issues and had not been taking her prescribed medication for the diagnosis for an unknown amount of time. The SM was unstable and put the safety of SC and SS at risk. The SM had suicidal/homicidal ideations and threatened to harm herself and the children. The SC and SS were dirty and urine-soaked. The SC was suffering from a medical ailment and the SM was not getting medical care for him. The father had an unknown role.

Determination: Indicated | **Date of Determination:** 07/13/2017

Basis for Determination:
SCDFS found the SM failed to follow through with recommended doctor appointments after the SC was diagnosed with an acute respiratory ailment. The SM had a MH episode and threatened to hurt herself. The SM continually failed to attend to her children's needs. The SC and SS were found in urine-soaked clothes and diapers by the SCDFS Preventive Services worker. SC passed away on 5/19/17. SCDFS documented some credible evidence that the SC's lack of medical attention contributed to his death. The SS was removed from the care of the SM.

OCFS Review Results:
A Preventive Services worker and a public health nurse were working with the SM when the CPS report was made. SCDFS contacted the source to confirm the information received and a CPS history search was documented in the case receord. The Risk and Safety Assessments were completed timely. Contact was made with the SM's mental health provider within 24 hours of receiving the report and SCDFS was advised SM was not a threat to herself or others. SCDFS verified there was an OP in place against the BF for the SM, SC and SS. The 7-day safety-assessment was not accurately completed and the safety concerns in the home were not addressed with the SM.

Are there Required Actions related to the compliance issue(s)? __Yes __No

Issue:
Failure to provide safe sleep education/information
Summary:
There was no discussion of safe sleep practices documented in the case record.
Legal Reference:

13-OCFS-ADM-02
Action:
SCDFS will provide all caretakers with safe sleep education when there is a child under age of one in the home.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day safety assessment indicated there were no safety factors present and this was inaccurate.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
SCDFS will include all safety factors present when completing the safety assessment.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition **Summary:**
The SC and SS were found to be saturated in urine-soaked diapers and clothing as alleged in the SCR report, and there were remnants of drugs present in the home and accessible to the SS. SCDFS did not address these issues with the SM.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c) **Action:**
SCDFS will address all safety concerns as they are presented, including a discussion with the caretaker to alleviate the concerns.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/22/2016	Sibling, Female, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 1 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:
An SCR report was received alleging the SM had 3 of her children removed from her care by Child Protective in the past and suffered from a severe mental illness which was causing her to act unstable. The SM did not have a stable place to live and had been refusing any help offered to her. As a result the SM had been bringing the 1-year-old SS from place to place for different people to take care of her. The SM picked up the SS from the current person caring for her without making a adequate care plan for her. As a result the SS and SM had nowhere to stay and were homeless.

Determination: Unfounded | **Date of Determination:** 10/21/2016

Basis for Determination:
After several home visits and contact with collaterals, it was determined the SM did have MH issues but was stable. The SS and SM secured housing within a week of the report and the SM was maintaining employment. The SS was up to date with medical appointments and was appropriately cared for. The SM agreed to Preventive Services and there was a caseworker assigned that continued to work with the SM and SS when the investigation closed.

OCFS Review Results:
The source was contacted and CPS history was checked upon receiving the SCR report. The SM was bouncing around with the SS because the apartment she was moving into was not yet ready. The SM and SS were working with Preventive Services at the time of the report and continued to have contact. SCDFS assisted the SM in finding suitable housing and provisions for herself and the SS until she was able to move into her apartment. There was contact made with collaterals, including other LDSS staff regarding the SS's medical care and the condition of the apartment. Although the agency continued to work with the SM, at the time the investigation concluded no contact had been made with the BF.

Are there Required Actions related to the compliance issue(s)? __Yes __No

Issue:
Failure to provide notice of report

Summary:
SCDFS did not notify the BF of the existence of the CPS report.

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

Action:
SCDFS will add all absent parents to CPS reports and provide notice of existence regarding the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/30/2016	Sibling, Female, 10 Months	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unfounded	Yes
	Sibling, Female, 10 Months	Mother, Female, 26 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 10 Months	Mother, Female, 26 Years	Lack of Supervision	Unfounded	

Report Summary:
An SCR report was received stating the SM abused prescription medication and illicit drugs on a daily basis, to the point of impairment. The SM was alleged to be unable to care for the SS when under the influence. The report further alleged the SM did not regularly or adequately feed, bathe, dress or clean the SS. The SM was said to be sleeping while alone caring for the SS and leaving drugs and associated paraphernalia accessible to the SS.

Determination: Unfounded	**Date of Determination:** 08/05/2016

Basis for Determination:
SCDFS found that the SM was prescribed medication and taking it properly. There were both announced and unannounced visits to the home and no safety issues were noted. The SM was still working with Preventive services at the time the investigation was closed. The pediatrician was contacted as a collateral and reported the SM attends appointments and provides treatment for the child as needed. There was risk associated with SM's CPS history and MH issues, but there was no evidence to substantiate the allegations. The case was closed with support services in place to monitor the family functioning.

OCFS Review Results:
SCDFS spoke with the SM regarding the concerns on an ongoing basis throughout the investigation. Several collaterals were contacted and SM had support and resources to assist her in caring for the SS if she had to work or otherwise needed assistance. The pediatrician for the SS was contacted and had no concerns regarding the care the SS was receiving. There was also contact made with the SM's doctor regarding her prescriptions. SCDFS made several home visits, but were unable to see the inside of the home. The SM agreed to Preventive Services during the investigation. There was no effort to contact the BF and make him aware of the CPS report.

Are there Required Actions related to the compliance issue(s)? __Yes __No

Issue:
Failure to provide notice of report

Summary:
SCDFS did not notify the BF of the existence of the CPS report.

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

Action:
SCDFS will add all absent parents to CPS reports and provide notice of existence regarding the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/06/2016	Sibling, Female, 6 Months	Mother, Female, 26 Years	Inadequate Guardianship	Unfounded	No

Report Summary:
An SCR report was received by Columbia County CPS stating the SM and the PS were arguing and the SM was chasing the PS throughout the home and throwing glasses on the floor. The SS was sitting in a car seat on the floor where the SM was throwing the glasses. It was unknown if this caused injuries to the SS.

Determination: Unfounded	**Date of Determination:** 03/01/2016

Basis for Determination:
The PS and SM were interviewed and denied all allegations. The PS and SM denied any romantic involvement and reported the SM and SS were staying with the PS until they found a place of their own. Collateral contacts were made and there was no credible evidence to substantiate the allegations. The SM reported she would be moving out of the district soon.

OCFS Review Results:
The risk and safety assessments were completely accurately and timely. A collateral contact was made with the SS's pediatrician and there were no concerns. Home visits were done and both subjects were interviewed. There was an attempt to locate the BF of the SS. The appropriate determination was made to unsubstantiate the allegations.

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)
07/03/2015	Sibling, Female, 1 Days	Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 1 Days	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:
An SCR report was received with allegations of IG and PD/AM against the SM regarding a SS. The report alleged that the SM tested positive for cocaine after giving birth to the SS, earlier that day.

Determination: Unfounded	**Date of Determination:** 09/30/2015

Basis for Determination:
The SS did have a positive toxicology for cocaine at birth, as did the SM. The medical records were examined and there was no evidence that the exposure to drugs caused had any negative impact on the SS. SCDFS observed the SM to be attentive to the SS during visits. The pediatrician reported the SM was bringing the SS to all medical appointments and the SM was developing normally. The SM agreed to work with a nurse from Public Health, Preventive Services and was attending treatment. The SM did not exhibit further signs of substance abuse during the open case. The SM and SS moved to another district and the Preventive Services were transferred there.

OCFS Review Results:
SCDFS completed the risk and safety assessments timely and accurately. The source was contacted, CPS history was checked and notes were entered contemporaneously. SCDFS appropriately consulted with their legal department at times during the investigation. There were numerous visits made to see the SM and SS and the concerns that presented were

addressed. SCDFS had discussions with the SM and she identified the BF of the SS, but he was never notified of the report.

Are there Required Actions

Issue:
Failure to provide notice of report

Summary:
The BF was identified by the BM at the time of the CPS report, but the BF was not notified of the existence of the report. **Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
SCDFS will add all absent parents to CPS reports and provide notice of

[redacted]

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

2/2010-4/2010-An SCR report with allegation of IG was SUB against the SM regarding a SS.
2/2010-4/2010-An SCR report with allegations of LS and IF/C/S UNSUB against SM regarding a SS and an IG SUB against the SM regarding the same SS.
6/2010-8/2010-An SCR report with allegations of IG and IF/C/S SUB against the SM regarding a SS.
10/2010-11/2010-AN SCR report with allegations of IG and IF/C/S UNSUB against the SM regarding 2 SS.
11/2010-11/2010-An SCR report with allegations of IG and IF/C/S UNSUB against the SM regarding a SS.
12/2010-2/2011-An SCR report with allegations IG and LS UNSUB against the SM regarding a SS.
2/2011-3/2011-An SCR report with allegations of IG, IF/C/S and PD/AM UNSUB against the SM regarding 2 SS. 3/2011-4/2011-An SCR report with allegations of IF/C/S, LM and OTHER SUB against the SM regarding 2 SS. 2/2012-3/2012-An SCR report with an allegation of IG SUB against the SM regarding a SS and PD/AM UNSUB against the BM regarding a SS.
4/2012-4/2012-An SCR report with an allegation of IG SUB against the SM regarding a SS.
2/2013-4/2013-An SCR report with an allegation of IG UNSUB against the SM regarding a child in a home where she was living.

Known CPS History Outside of NYS

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

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 06/23/2016

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?				
Did the services provided meet the service needs as outlined in the case record?				
Did all service providers comply with mandated reporter requirements?				
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?				
If yes, was the response appropriate to the circumstances?				

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?				
Were face-to-face contacts with the child in the child's placement location made with the required frequency?				

Services Provided

	Yes	No	N/A	Unable to Determine
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?				
Were services provided to parents as necessary to achieve safety, permanency, and well-being?				

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?				
If not, how many days was it overdue? The FASP was due 8/15/17 and had not been launched when this report was written.				

Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?				

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?				

Additional information, if necessary:
Preventive Services were provided by SCDFS and there was an additional worker providing services as well.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes __No

Issue:	Timeliness of completion of FASP
Summary:	The FASP due in August of 2017 was not completed when this report was written.
Legal Reference:	18 NYCRR428.3(f)
Action:	SCDSS will complete FASP within the regulatory timeframe.
Issue:	Failure to provide safe sleep education/information
Summary:	There is no documentation in the case record that the SCDSS Preventive worker discussed safe sleep practices with the SM. The SM had an infant during the open case.
Legal Reference:	13-OCFS-ADM-02
Action:	SCDSS will document providing safe sleep education to caregivers when there is a child under 1-year-old in the home.

Preventive Services History

There was a Preventive Services Case opened 8/31/2010 for the SM, 7-year-old SS and the BF of the SS. They were living in unsafe and unsanitary conditions. The SS lived with his PA from January 2010-August 2010 because she was awarded custody for that period of time. In August of 2010 the parents regained custody. The services were provided to the SM and BF in an effort to support the parents with budgeting, parenting and housekeeping. In September of 2010 the 6-year-old SS was born. The preventive case became a foster care case in when the eldest 2 SS were removed.

The SM had a another child in July of 2015 and a Preventive Case was open 7/4/15-8/25/15 because the SM tested positive for drugs. The SM and the SS moved and a new case was opened in this county on 8/25/15 and closed 12/17/15 when the SM moved.

Another case was opened on 6/23/16 due to SM's CPS history, to support the SM in caring for the SS and later the SC in her care.

The services provided in the preventive cases opened in 2015 and 2016 were parent education, housing assistance, a parent aide and substance abuse counseling.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?				

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐ Yes ☒ No

Foster Care Placement History

In April 2011 a foster case was opened when the 6-year-old and 7-year-old SS were removed from the SM and BF and placed in foster care. The preventive case that was open became a foster care case. In February 2012 the 5-year-old SS was born and also removed. The BF was the father to all 3 of the SS that were removed. The youngest SS went to live with a familial resource as ordered by a Family Court Judge. In May of 2013 the SM and BF surrendered their rights to the eldest 2 SS. In January of 2015 the BF was given custody of the 3rd SS and the SM had no visitation rights. The case closed in June of 2015 because SM had no SS in her care and the BF no longer needed services.

Legal History Within Three Years Prior to the Fatality

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

Additional Local District Comments

Although it was not adequately documented, the Department did address safe sleeping with the mother. Additionally, several other providers addressed safe sleeping with her as well.

The father of the sibling is unknown; therefore notification of the existence of a CPS report could not be provided.

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