Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-004

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

Issue Date: Jul 12, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 01/26/2023
Initial Date OCFS Notified: 01/27/2023

Presenting Information

Suffolk County Department of Social Services (SCDSS) received an SCR report which alleged that at an unknown time on 1/26/2023, the 7-week-old subject child passed away. There were no details regarding the circumstances. This was an otherwise healthy child.

Executive Summary

This report concerns the death of a 7-week-old child that occurred on 01/26/23. SCDSS had an open CPS investigation at the time of the death; however, a new report was registered on 01/27/2023 regarding the subject child's death. The open investigation began on 12/07/2022 due to concerns the subject mother was homeless and impaired on an unknown substance when she arrived at the hospital to visit and care for the newborn subject child after her birth. At the time of her death, the subject child resided with the mother, maternal grandmother and 13-year-old surviving sibling. The mother, grandmother and father had CPS history. There were two surviving half-siblings who were both seen and assessed to be safe in the care of their perspective caregivers.

SCDSS completed collateral and casework contacts and learned that on the evening of 01/26/23, the mother bottle fed the subject child between approximately 7:30PM and 8:30PM, played with the child for 45 minutes and then laid the child on her back in the mother's twin-sized bed. The mother laid down next to the subject child a little while later and they both fell asleep. At approximately 10:30PM, the mother woke up and noticed the subject child was unresponsive. The mother alerted the grandmother and 13-year-old sibling. The 13-year -old sibling called 911 and along with the mother initiated CPR with the assistance of the 911 dispatcher. Emergency medical services arrived, continued life-saving measures, and transported the subject child to the hospital. Hospital staff took over life-saving measures; however, were unsuccessful and the subject child was pronounced deceased at 11:58PM.

An Autopsy was performed; however, the final autopsy report had not been received at the time this report was written. The law enforcement investigation remained open pending the final autopsy results.

SCDSS substantiated the allegation of Inadequate Guardianship and Lack of Medical Care against the mother as it was determined the mother did not bring the subject child to a follow-up appointment to monitor her weight. SCDSS unsubstantiated the DOA/Fatality allegation against the mother, citing that if the autopsy revealed further concerns a new SCR report would be generated. SCDSS unsubstantiated the allegations of Inadequate Guardianship and DOA/Fatality against the grandmother.

SCDSS offered the family services in relation to the death of the subject child which were declined. The CPS investigation was indicated and closed on 03/27/23

PIP Requirement
SCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify actions the SCDSS has taken, or will take, to address the cited issues. For issues where a PIP is currently implemented, SCDSS 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:
There was detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the case circumstances.

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:
There was detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The BF was listed as the secondary caretaker; however, the record reflected BF had only met the SC twice and did not have caretaking responsibilities of the SC. The MGM lived in the home with the SC and was listed as an alleged subject.
Legal Reference:	18 NYCRR 432.2(d)
Action:	SCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/26/2023 **Time of Death:** 11:58 PM

County where fatality incident occurred:	Suffolk
Was 911 or local emergency number called?	Yes
Time of Call:	10:50 PM
Did EMS respond to the scene?	Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs?	Unknown

Child's activity at time of incident:

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

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Father	No Role	Male	33 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	72 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Other Adult - Siblings birth father	No Role	Male	50 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	13 Year(s)

LDSS Response

SCDSS initiated their investigation by coordinating their efforts with LE. SCDSS offered services to the family, spoke with collateral sources, interviewed the parents, subjects and SSs, and conducted home visits. The 6yo SS and the 13yo SS were assessed to be safe with their respective caregivers.

SCDSS interviewed the SM and MGM together and learned that on 1/26/23, the SM fed the SC a bottle between 7:30PM and 8:30PM, burped the SC and then played with her for approximately 45 minutes. The SM laid the SC down on the SM's twin-sized bed. The SM then laid in the bed next to the SC and they both fell asleep. The SM woke up at approximately 10:30PM, checked on the SC and discovered the SC was unresponsive and yelled for the MGM's assistance. The MGM took the SC from the mother and ran down the stairs to the main living area of the home; the 13yo SS and the SM followed. The 13yo SS called 911 and along with the SM initiated CPR via 911 dispatcher instructions until EMS arrived and took over with CPR efforts. The SC was transferred to the hospital via ambulance. Life-saving

measures continued at the hospital; however, they were unsuccessful, and the SC was pronounced deceased at 11:58PM.

SCDSS interviewed the SSs. The 13yo SS was home during the fatal event; however, declined to discuss the event. The 6yo SS resided in a separate household with the BF and was interviewed at school. The 6yo SS was not present for the fatal event and had only met the SC twice. The SSs reported feeling safe in their respective households and reported no concerns to SCDSS. The SSs were observed to be free from visible marks and bruises. SCDSS interviewed the BF who revealed he was not aware the SM was co-sleeping with the SC but did know the SC had a bassinet. The BF had only seen the SC approximately three times before her death and reported the SM would often not allow the BF access to the SC.

SCDSS observed a bassinet in the SM's bedroom near her bed; however, there were books and toys inside the bassinet. The SM and MGM stated the SC co-slept with the SM every night and never used the bassinet. The SM stated the SC was fussy for days but easily consoled by SM. The SM reported the SC was acting fine the day that she passed away, and nothing was out of ordinary. There was documentation from the pediatrician's office and SCDSS that safe sleep guidelines were reviewed with SM.

SCDSS learned through medical records and interviews that the SM has a history of substance misuse and was on several prescribed medications and used unprescribed marijuana. In the bedroom where the SC and SM slept a marijuana pipe was found on the windowsill and a small container of marijuana was found on the dresser. The record contained photos of the twin-sized bed where the SC and SM co-slept. The bed was observed to have several pillows of various sizes and multiple blankets. During the interview with the SM, she appeared impaired and was unable to provide an accurate account of what occurred leading up to the death of the SC.

The ME stated the SC had blood pooled in the front of her body consistent with SC having been on her stomach face-down with compression to her abdomen. This information contradicted what the SM reported as having said she initially laid the SC on her back and subsequently found her on her back unresponsive. SCDSS learned from the ME that the preliminary results of the autopsy revealed the SC had red congestive lungs and a left ovarian hernia as incidental findings but not the cause of death. The one routine pediatric appointment the SC attended noted a concern for the SC losing birth weight but otherwise appearing healthy and well developed. The SC had no other noted health conditions. The pediatrician requested to see the SC for a follow-up four days after the initial appointment to monitor the SC weight, but the SM failed to bring the SC to the appointment or reschedule.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063589 - Deceased Child, Female, 1 Mons	063591 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated

063589 - Deceased Child, Female, 1 Mons	063591 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Substantiated
063589 - Deceased Child, Female, 1 Mons	063591 - Mother, Female, 40 Year(s)	Lack of Medical Care	Substantiated
063589 - Deceased Child, Female, 1 Mons	063592 - Grandparent, Female, 72 Year(s)	DOA / Fatality	Unsubstantiated
063589 - Deceased Child, Female, 1 Mons	063592 - Grandparent, Female, 72 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☐	☒
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The BF to the 13yo SS was not interviewed face to face; however, the record does reflect diligent efforts to do so. The BF to the 13yo SS was spoken to over the phone.

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	☒	☐	☐	☐

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

Infant was born:

☒ With a positive toxicology
☒ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☐ With none 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)	Allegation Outcome	Compliance Issue(s)
01/20/2023	Sibling, Female, 6 Years	Other Adult - surviving sibling's birth mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Other Child - surviving sibling's half sibling, Male, 12 Years	Other Adult - surviving sibling's birth mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - surviving sibling's half sibling, Female, 15 Years	Other Adult - surviving sibling's birth mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report dated 1/20/23 alleged the BM to the then 6-year-old SS had a history of misusing prescription and nonprescription drugs. The BM to the then 6-year-old SS previously gave birth to five children who were each born with a positive toxicology and experienced withdrawal symptoms. The role of the BF was unknown.

Report Determination: Unfounded | **Date of Determination:** 01/26/2023

Basis for Determination:
SCDSS spoke with collateral contacts who reported that the BM to the then 6-year-old SS did not have custody of any of her CHN. The collateral contacts verified that the then 6-year-old SS and her half siblings had been placed in the custody of relative caregivers. SCDSS contacted LE who verified the BM to the then 6-year-old SS did give birth to a still born baby and had a miscarriage. The BM to the then 6-year-old SS buried the child she miscarried in the woods next to a tent she was residing in. SCDSS observed the children listed on the report except one child that was adopted and documented there were no further concerns.

OCFS Review Results:
SCDSS did not locate the BM of the children listed on the SCR report. The record did not reflect diligent efforts to locate that BM. Interviews of the alleged maltreated children did not adequately assess their safety in the care of their perspective caretakers.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
SCDSS did not conduct full interviews of all of the alleged maltreated children that were listed on the report to ensure they are safe with their current caretakers.

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

Action:
SCDSS will incorporate key safety-related questions as they pertain to case circumstances.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/07/2022	Deceased Child, Female, 3 Days	Mother, Female, 40 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 3 Days	Mother, Female, 40 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report dated 12/7/22 alleged the SM gave birth to the SC on 12/4/22. The SM did not have housing or a plan for housing for herself and the SC. Yesterday, 12/06/22 and today, 12/7/22, the SM was under the influence of an unknown substance when she planned to act as the caretaker for the SC. The SM was delirious and incoherent and as a result could not care for the subject child. The SC died during this open investigation.

Report Determination: Indicated | **Date of Determination:** 02/03/2023

Basis for Determination:
SCDSS determined there was evidence to support the allegations of IG and PDAM as collaterals observed the SM attempting to care for the SC while she was under the influence of an unknown substance. The SM and BF reported that they believed the SM's bizarre behavior was a misunderstanding by those who witnessed it. SCDSS confirmed that SM was homeless at the time of the SC birth and did not have a plan for housing. The SC did experience withdrawal symptoms from the positive toxicology she had at birth and was retained in the hospital until she was medically cleared for discharged.

OCFS Review Results:
SCDSS assessed the safety of all CHN, conducted home visits, and interviewed the parents. SCDSS offered preventive services, which the SM was receptive to; however, there was no documentation SCDSS followed up, despite the need for services. The record did not reflect SCDSS discussed the effects the SM's use of prescription medication had on her ability to care for the CHN. The SM appeared under the influence while visiting the SC in the hospital, but there was no documentation that substance misuse was addressed with the parents. SCDSS was unaware a Plan of Safe Care was completed until after the SC's death, and therefore, no plan was monitored after the SC's discharge from the hospital.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
SCDSS completed the 7-day safety assessment and inaccurately applied the safety criteria reflecting there was no immediate or impending danger to the SC. The age, vulnerability, seriousness and number of safety factors placed the SC in immediate or impending danger. A safety plan to ensure there was a sober caretaker for the SC was warranted and but was not implemented by SCDSS.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP was completed inaccurately. The RAP did not reflect current and past circumstances related to domestic violence, drug use and unstable housing for the caretakers accurately.
Legal Reference:
18 NYCRR 432.2(d)
Action:
SCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Issue:
Failure to complete, document, and monitor a Plan of Safe Care
Summary:
The record reflected SCDSS was unaware if a Plan of Safe Care had been completed until after the SC was deceased therefore a Plan of Safe Care was not being monitored.
Legal Reference:
17-OCFS-LCM-03 & 18-OCFS-LCM-06
Action:
SCDSS will complete, document & monitor a Plan of Safe Care that specifically addresses the child affected by

substance misuse and the affected caregiver. SCDSS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/11/2021	Sibling, Female, 4 Years	Father, Male, 31 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 4 Years	Father, Male, 31 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report dated 1/11/21 alleged that on an on-going basis the BF was impaired by synthetic marijuana and was unable to safely be the sole caregiver for the then 4-year-old SS.

Report Determination: Indicated **Date of Determination:** 02/24/2021

Basis for Determination:
SCDSS conducted interviews with the BF, PGM, great aunt (OA) and the SS along with collateral contacts. SCDSS was made aware that the BF had a significant history of misusing drugs including several police reports. The SS reported extensive drug knowledge related to the BF. The SS had been removed from the BF's custody in the past and SCDSS filed a petition against the BF and placed the SS in the PGM's custody again with supervised visitation for the BF. A long term services case was opened to address the needs of the BF and SS.

OCFS Review Results:
SCDSS did not document efforts to locate the BM. Full interviews were not completed with the BF and the PGM in an effort to adequately fill out the RAP tool and access for risk. The PGM should have been listed as the secondary caretaker in the RAP. The PGM lived in the same home as the then 4-year-old SS and BF and had significant caretaking responsibilities for the then-4-year-old SS and ultimately gained custody of the child at the time the investigation closed.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
SCDSS did not ask questions to adequately answer the risk elements in the RAP tool. The PGMA resides in the home and was awarded custody of SS at the conclusion of the investigation. The PGMA should have been listed as the secondary caretaker.

Legal Reference:
18 NYCRR 432.2(d)

Action:
SCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
SCDSS added the SS's BM to the report and mailed a notification letter about the investigation; however, the record did not reflect diligent efforts to interview her.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
SCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

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

Between May 2009 and March 2018 the SM and 13yo SS were listed in three indicated cases for PD/MA and IG and one unfounded case of the same allegations. All three reports had similar concerns for the SM misusing drugs while being the sole caretaker for the 13yo SS. There was a neglect petition filed and the 13yo SS was removed from the SM's custody during the March 2014 investigation. The MGM was listed as a subject in the one unfounded case. The MGA was listed as no role in the indicated cases between 3/2014 and 11/2015.

There was one indicated investigation from June 2016 against the BF and the BM to the 6yo SS for IG and PD/AM regarding the 6yo SS. The parents were unable to care for the 6yo SS due to substance misuse. The 6yo SS was removed from the parent's care and remained in a relative foster care placement until October 2017.

Preventive Services History

A Family Services Intake was opened 05/02/2018 through 07/24/2018 due to a court ordered investigation after the BF to 13yo SS filed for custody of 13yo SS. The BF alleged that the SM and MGM would not allow the BF to the 13yo SS to see him. At this time MGM had custody of 13yo SS due to both parent's drug misuse. MGM retained primary physical custody of child. The record reflected the case was closed due to no evidence that the 13yo SS was being abused or neglected by his parents or MGM.

Foster Care Placement History

A Family Services Stage opened on 02/22/2021 though 05/09/2022 as a result of a neglect petition against the BF with a removal of the 6yo SS because of the BF's drug misuse. The 6yo SS was placed in the custody of PGM and a stay away order of protection was ordered with the exception of visitation supervised by PGM or LDSS. The BF was able to successfully complete his court mandated programs for mental health, parenting and substance abuse and regained custody of the 6yo SS on 05/09/2022.

A Family Services Stage was opened from June 2016 through October 2017 as a result of a neglect petition with a removal from the BF and BM to the 6yo SS. The BF to the 6yo SS completed all mandated programs. The BM to the 6yo SS refused to engage in all mandated programs. The 6yo SS was returned to the BF's custody in April 2017.

A Family Services Stage was opened on 03/26/2014 as a result of a neglect petition with removal of the 13yo SS. The SM had a significant substance misuse history resulting in criminal activity and inpatient treatment. There was initially a stay away order of protection against the SM in favor of 13yo SS that was vacated at the case closure. Custody of the SS was awarded to maternal grandparents.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain:	

An order of protection was issued in favor of the 6yo SS against the BF to the 6yo SS due to substance misuse. The order of protection was vacated and the BF regained custody of the 6yo SS on 05/09/2022.

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