Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-054

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

Issue Date: Jan 05, 2024

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		

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 09/19/2023
Initial Date OCFS Notified: 09/19/2023

Presenting Information

An SCR report was received on 9/19/23, which stated at approximately 5:00AM, the paternal grandmother discovered that the subject child was not breathing. The grandmother called 911, then attempted to resuscitate the child on a mattress. Emergency medical services and law enforcement responded to the home. The child was not breathing and did not have a pulse. Paramedics intubated and transported the child to the hospital, where she was pronounced dead upon arrival. The child was an otherwise healthy child, and the grandmother and parent substitute had no explanation for her death. A duplicate report was received on 10/20/23, which stated two weeks ago, the grandmother was co-sleeping with the child and rolled over on her. As a result, the child died.

Executive Summary

This report concerns the death of the 1-month-old female subject child. Orange County Department of Social Services (OCDSS) received an SCR report regarding the child's death on 9/19/23, as well as a duplicate report on 10/20/23. At the time of the child's death, she resided with her paternal grandmother, the grandmother's paramour, the paramour's adult sibling, as well as, her four siblings, ages 9, 8, 5, and 3. The children's mother and father resided elsewhere, and separately. The parents had mental health and physical limitations which impacted their parenting abilities and as such, had supervised visitation with the children. The grandmother had been the children's primary caretaker since 2018, an arrangement informally made by the family.

During the evening of 9/18/23, the subject child was fussy. The grandmother gave the child a bottle at 10:30PM and put her down to sleep in a small infant chair, in which the child could be buckled into. Around 1:30AM on 9/19/23, the child woke up fussy, so the grandmother brought her into the living room, and laid down on the air mattress, which was shared with the 5 and 3-year-old siblings, with the subject child on her chest. Once the child fell asleep, the grandmother placed her on her back, next to her, on the mattress. The child was between the grandmother and the wall, and the two siblings were sleeping at the foot of the mattress. The grandmother again woke up at 5:00AM and felt the mattress moving and checked on the subject child, who was in the same position. The grandmother touched the child, and she was unresponsive. The grandmother tried to rouse the child and when she was unable to, she placed the child on the floor and began CPR. The grandmother called out for someone to call 911, which her paramour did. Emergency medical services arrived and transported the grandmother and child to the hospital, where the child was pronounced deceased.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation was closed; however, the record reflected the medical examiner intended to label the death as, "unexplained death in an environment of unsafe sleep." Toxicology was negative, but the child was found to be positive for salmonella. Further testing was pending, and the significance of that finding was unknown at the time the CPS investigation closed. It was unknown how the child contracted salmonella and the Department of Health followed-up with the family, none of whom had symptoms. There were no marks or bruises to the child, and a skeletal survey showed no broken bones. There were no arrests made in response to the fatality.

OCDSS made several home visits and interviewed the adults residing in the home, the adult family members who had been visiting the home the night of the fatality, the verbal siblings, and the parents. The siblings were assessed to be safe in the grandmother's care.

OCDSS substantiated the allegation of Inadequate Guardianship against the grandmother. The grandmother routinely

placed the child in an unsafe sleep environment and did so on the night of the fatal incident, by placing the child on an air mattress with herself and two siblings. Due to the cause of death being unexplained pending further studies, the DOA/Fatality allegation was unsubstantiated. Allegations against the paramour were unsubstantiated as he did not have a caretaking role to the child.

All family members were provided bereavement services and the grandmother accepted the services offered by OCDSS for herself and the siblings.

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The safety of the siblings at the grandmother's home was assessed throughout the open investigation; however, the Safety Assessment tool was not completed at 30-Days, as required for a report containing a DOA/Fatality allegation. The children had resided with the grandmother since 2018 in a safety plan made by the family, due to the parents' chronic mental health needs, alcohol use, and health issues. There had been no family court intervention and the safety plan remained family-directed. The Safety Assessments were completed based on the grandmother's household, rather than the household of origin, and therefore did not reflect the ongoing intervention of the safety plan. There were no safety factors identified in the grandmother's home, and the siblings were assessed safe based on the grandmother remaining the

caretaker. The parental capacity to protect the siblings had not changed, therefore, the safety plan continued to be warranted. The parents had supervised visitation at the grandmother's home. No further service needs were identified or requested, and the CPS investigation was closed on 11/17/23.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	There was no 30-Day Safety Assessment completed in CONNECTIONS for this investigation.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, a safety assessment will be documented and approved by a supervisor within 30 days of a report if such report contains the allegation of DOA/Fatality.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/19/2023 **Time of Death:** Unknown

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

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	Grandparent	Alleged Perpetrator	Female	56 Year(s)
Deceased Child's Household	Other Adult - Grandmother's Paramour	Alleged Perpetrator	Male	54 Year(s)

Deceased Child's Household	Other Adult - Paramour's Adult Sibling	No Role	Male	52 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Mother	No Role	Female	32 Year(s)
Other Household 2	Father	No Role	Male	37 Year(s)

LDSS Response

On 9/19/23, OCDSS received the initial SCR report regarding the death of the subject child. OCDSS initiated the investigation immediately and coordinated their efforts with law enforcement and the ME's office. OCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. OCDSS assessed the safety of the siblings and conducted an initial home visit the same date the report was received.

OCDSS interviewed all adults who were present in the home regarding the events leading up to the child's death. As the primary caretaker to the child, the grandmother (PGM) provided a timeline of the incident. On 9/18/23, the PGM gave the child a bottle and put her down for bed in the infant chair the child regularly slept in. There was no safe sleep environment available to the child in the home. The chair was something the child could be strapped into, and PGM did so, leaving a two-finger width space so as not to be too tight. This chair was placed in the kitchen. Around 1:30AM, the morning of 9/19/23, the child woke up fussy, so the PGM took the child out of the chair and brought her to the living room, where the PGM was sleeping on an air mattress with the 5 and 3yo siblings. The PGM laid down with the child on her chest until the child fell asleep, at which time the PGM placed the child, on her back, on the mattress next to her. The PGM and children were sleeping on the air mattress because company was in town to visit the child and they were given the beds upstairs. The siblings were at the foot of the mattress and the child had space around her. A doll reenactment confirmed the placement of the child, with about 4-5 feet of space between the child and siblings, about 5 feet of space between the child and wall, and about 2 feet of space between the child and PGM. The PGM next woke up around 5:00AM and felt the mattress moving, which she though might have been the autistic 5yo. When she turned over, she observed the subject child in the same position she had laid her in, but when she touched the child, the child was unresponsive. Unable to rouse the child, the PGM initiated CPR and yelled out for someone to call 911.

OCDSS interviewed the other adults who resided in the home. Both reported being woken to the PGM's yelling the morning of 9/19/23. Neither had any concerns about the PGM's ability to care for the children. The three adults visiting the home the night of the fatal incident were interviewed as well and had nothing additional to add, and reported no concerns for the child during their visit. The 9 and 8yo siblings were interviewed and reported feeling safe with their PGM and reported no concerns within the home and that the subject child was a happy baby, and no one got mad with the child. The 5yo was unable to be interviewed due to limitations, and the 3yo was not interviewed.

The mother was psychiatrically hospitalized at the time of the child's death and was released to supportive housing due to her mental health needs. The father resided in a separate residence. Neither parent had concerns with the PGM's care of their children.

Additional collateral contacts with the pediatrician and schools identified no concerns. The subject child was seen by the pediatrician on 8/4/23 and 9/13/23 without concern. School staff reported the PGM was communicative, and they never had an issue, though did feel the family could benefit from assistance around the death.

Bereavement services were offered to the PGM, siblings, mother, and father. At the close of the investigation, the PGM

and siblings had engaged in services. Burial assistance was offered; however, the PGM reported the funeral home covered the costs. The father requested a substance use referral to address his alcohol use, which was provided. Safe sleep was reviewed with the PGM in the event another infant comes to live in her home. The children's pediatrician assisted with a Thanksgiving basket for the family and the PGM was provided with contact information for community-based programs, which she was encouraged to reach out to if the need arose.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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 referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065551 - Deceased Child, Female, 1 Month(s)	065557 - Other Adult - Grandmother's Paramour, Male, 54 Year(s)	DOA / Fatality	Unsubstantiated
065551 - Deceased Child, Female, 1 Month(s)	065557 - Other Adult - Grandmother's Paramour, Male, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
065551 - Deceased Child, Female, 1 Month(s)	065556 - Grandparent, Female, 56 Year(s)	DOA / Fatality	Unsubstantiated
065551 - Deceased Child, Female, 1 Month(s)	065556 - Grandparent, Female, 56 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

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

Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

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.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The grandmother continued to be the family's safety resource for the children. Burial assistance was offered; however, not needed as the funeral home covered the cost. The father requested and was provided a substance use referral. The mother continued to receive mental health services relevant to her diagnoses. The grandmother and siblings had engaged in bereavement services prior to the CPS investigation closing.

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 siblings were referred to grief counseling services. At the time the CPS investigation closed, the grandmother had the family engaged in services and a therapist was coming to the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
All immediate family members were provided with referrals to grief counseling services. The grandmother had engaged her household, which included the siblings, in services. Information on additional community-based services were provided to the grandmother as well. Though referred, it was unknown if the father or mother engaged in bereavement specific service, nonetheless, both had additional service providers for support and to assist with referrals in the future, if needed.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

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)
12/02/2021	Sibling, Male, 7 Years	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 7 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6	Mother, Female, 30	Parents Drug / Alcohol	Unsubstantiated	

Years	Years	Misuse	
Sibling, Male, 3 Years	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 3 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 1 Years	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 1 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
OCDSS received an SCR report on 12/2/21 which alleged that the mother and father were staying at the paternal grandmother's (PGM) home, visiting the siblings. The parents had been drinking alcohol for the past two days. The mother had a mental health diagnosis and was prescribed medication, which she had not been taking. The parents were intoxicated the morning of 12/2/21 when the mother tried to cut her wrists with a knife in the presence of the siblings. Either the father or PGM called the police. The mother was taken to the hospital. The father and PGM had unknown roles.

Report Determination: Indicated | **Date of Determination:** 03/27/2023

Basis for Determination:
OCDSS substantiated the allegations of IG against the mother regarding the siblings. An exception to the visitation plan had been made over the Thanksgiving holiday, and the mother and father had stayed overnight at the PGM's home due to a COVID-19 quarantine. One evening, the parents obtained alcohol from a local store and drank. The following morning, the mother engaged in an argument with the father in front of the siblings, grabbed a knife, and made suicidal statements in front of the siblings. The mother was hospitalized as a result and the siblings spoke about the upsetting statements their mother made. The allegation of PD/AM was not addressed.

OCFS Review Results:
Although the investigation was initiated timely in that the children, PGM, and father were interviewed; the mother was engaged minimally and untimely. There were limited attempts to elicit information from collateral sources who could provide information on the parents' mental and health statuses. There were large gaps in casework activity resulting in an untimely determination. It was learned the mother was pregnant at the end of the investigation. Although she was hospitalized, she was not engaged around planning for the care of that child.

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

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

Summary:
The mother was interviewed four months after the initiation of the case, and the entirety of the allegations were not addressed with her. There was no follow-up with the mother once it was learned the mother was pregnant as to what her plan was for the care of the unborn child.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDSS 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.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
There were missed opportunities to gather collateral information from the mother's mental health providers, including from her two inpatient hospitalizations during the course of the open investigation.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
OCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
The mother was not asked about the alleged alcohol use on the night of the reported incident.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
OCDSS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated children.

Issue:
Failure to provide safe sleep education/information
Summary:
During the investigation, OCDSS learned the mother was pregnant and due in August 2023. Safe sleep discussions were not had with the mother, nor with the PGM, who expressed intent to care for the unborn child.
Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1
Action:
OCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
OCDSS had no contact with the children on the case from 12/2/21 to 3/27/23. There were gaps in casework activity from 12/21/21 to 4/5/22; 4/19/22 to 12/21/22; 12/21/22 to 3/24/23.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
OCDSS must continue to gather information to reassess safety of the children, throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3).

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Over 40% of progress notes were entered on 3/27/23, the date the case was closed, including the initial home visit that occurred on 12/2/21. Of the progress notes that were recorded late, they were entered between 3 and 15 months beyond the event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the

information which is to be recorded.

Issue:
Timeliness of Determination

Summary:
This investigation remained open from 12/2/21 to 3/27/23 without consistent casework or collateral contact to document the continued need for CPS intervention.

Legal Reference:
SSL 424(7);18 NYCRR 432.2(b)(3)(iv)

Action:
OCDSS will make a determination of either "indicated" or "unfounded" within 60 days after receiving the report.

[redacted]

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

The family's history with OCDSS dates to May 2014, when the 9yo sibling was 4 months old. There were concerns regarding the mother's mental health needs, and the risk her acute psychotic state at the time posed to the sibling. The investigation was assigned to the Family Assessment Response (FAR) track. The maternal grandparents were utilized to support the parents in caring for the sibling and the case was closed on 7/9/14. As it had been assigned FAR, no determination of the allegations was made. The family participated in a FAR case again, from 8/25/14 to 4/26/16, stemming from concerns of the father's mental health and his ability to care for the sibling while the mother was psychiatrically hospitalized. During the open case, the sibling went to reside with the maternal grandparents. Intent to close the case in November 2014 was noted; however, the case remained open without the required casework contacts until a subsequent report was made on 8/6/15, following the birth of the 8yo sibling. That report contained concerns about the mother's ability to care for the two children given her mental health needs. At the close of the two cases on 4/26/16, the maternal grandparents had custody of the 9yo sibling, and the 8yo sibling resided with the parents and PGM. An 8/19/16 investigation regarding allegations of the parents' drug and alcohol use was unfounded. The 9yo sibling had returned to living with the parents at the close of that investigation. Concerns about the impact of the mother's mental health on her ability to care for the siblings was again expressed in a 9/11/17 SCR report, which was assigned FAR. It was learned the mother was pregnant with the 5yo sibling, and therefore unable to take her regular medication and consequently unable to stabilize her mood. The PGM had moved in with the parents and siblings. It was also discovered the siblings were well behind on medical appointments and at the close of the FAR case, were being brought up to date. Again, concerns about the mother's mental state were made to the SCR on 7/18/18, and the case was assigned to FAR. At closing, the 9, 8, and 5yo siblings were residing with the PGM, who was considering filing for custody at the time the case was closed. At the time of the fatality, the PGM had not filed for custody.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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