Child Fatality Report

Report Identification Number: SY-17-031

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

Issue Date: Jan 09, 2018

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: St. Lawrence
Gender: Male
Date of Death: 07/15/2017
Initial Date OCFS Notified: 07/16/2017

Presenting Information

An SCR report was received on 7/16/17, and alleged on the afternoon of 7/15/17, while in the care of SM, SF, and MGF, SC was found unresponsive in a bed in the home. SC was placed down for a nap at approximately 2:30PM, and an hour and a half later was found by one of the adults not breathing. MGF performed CPR, and EMTs responded to the home. SC was transported to the hospital where he was pronounced deceased. SC had no preexisting medical conditions that contributed to his death, and was an otherwise healthy child. The role of the SS was unknown.

Executive Summary

This fatality report concerns the death of a 2-year-old male (SC) that occurred on 7/15/17. A report was made to the SCR on 7/16/17, with allegations of DOA/Fatality and IG against MGM, SF, and SM regarding SC. St. Lawrence County Department of Social Services (SLCDSS) conducted a thorough investigation surrounding SC's death. An autopsy was performed and determined the cause of death was heat stroke with dehydration and acute hyperthermia, and the manner was accidental.

SC was a healthy CH, up to date medically, and had no ongoing medical issues. SC resided with his 3-year-old brother (of whom SF was not the biological father) in the care and custody of MGM and MGF; SM and SF had joint custody with supervised visitation. It was discovered that on 7/15/17, the weather was particularly warm and the CHN had spent most of the day playing outside in their kiddie pool. SM and SF were at the grandparents' home that day, visiting with the CHN. SC was placed down for a nap at approximately 2:30PM. MGF checked on SC once, around 3:30PM, and SC appeared fine. SM went to wake SC from his nap around 4PM, and found him in distress. Emergency services were called and transported SC to the hospital, where he was pronounced deceased. Interviews revealed SC had been acting normally throughout the day of the incident, and showed no signs of being overheated or dehydrated.

From the time the investigation began to the time of its closure, SLCDSS met with and interviewed MGM, MGF, SM, and SF, followed up with numerous collateral contacts, and referred the family to appropriate services. The 24-Hour and 7-Day Safety Assessments were completed timely in CONNECTIONS, but they did not speak to the safety of the SS, only of SC and the circumstances surrounding his death; however, the progress notes reflected the home environment was observed to be appropriate, and the SS was assessed to be safe. The case record did not reflect if SLCDSS made any attempts to interview the SS's biological father. SLCDSS gathered sufficient information to unsubstantiate all allegations and close the case.

Review of this investigation resulted in citations related to certain casework practices in regards to SLCDSS. Review of historical investigations conducted in Jefferson County Department of Social Services (JCDSS) resulted in citations related to JCDSS overall casework practices. In response, SLCDSS and JCDSS will each submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. These PIPs will identify what action(s) SLCDSS and JCDSS have taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, SLCDSS and JCDSS will review the plan(s) and revise as needed to further address on-going 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:
SLCDSS completed a thorough investigation into the circumstances surrounding SC's death. The investigation determination safety assessment was adequate, and the decision to UNF and close the case was appropriate.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The casework was commensurate with the case circumstances. SLCDSS' decision to UNF and close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or childs parents or guardians
Summary:	There were no documented efforts to interview the biological father of the SS.
Legal Reference:	432.1 (o)
Action:	SLCDSS will interview, or attempt to interview, the biological fathers of all children named on a report.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	Although the 24 Hour Assessment was completed timely in Connections, it did not speak to the safety of the SS; only the circumstances surrounding SC's death.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	Within 24 hours of receiving a report, the child protective service must provide information about whether the surviving child(ren) may be in immediate danger of serious harm and document such accordingly in the Initial Safety Assessment.

Issue:	Timely/Adequate Seven Day Assessment
Summary:	Although the 7 Day Assessment was completed timely in Connections, it did not speak to the safety of the SS; only the circumstances surrounding SC's death.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	Within seven days of receiving a report, SLCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/15/2017 **Time of Death:** 06:00 PM

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

County where fatality incident occurred: St. Lawrence
Was 911 or local emergency number called? Yes
Time of Call: 04:10 PM
Did EMS 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:

- ☒ 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? 2 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 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	50 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	50 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

Other Household 1	Father	Alleged Perpetrator	Male	32 Year(s)
Other Household 1	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 2	Other Adult - BF of SS	No Role	Male	22 Year(s)

LDSS Response

On 7/16/17, SLCDSS received a report regarding the death of SC. SLCDSS initiated their investigation within 24 hours, and coordinated their efforts with LE. SLCDSS contacted the source of the report and reviewed CPS history. SLCDSS learned SC resided in the care and custody of his maternal grandparents, along with SS; SM and SF had joint custody with supervised visitation.

SLCDSS first met with MGM and MGF at their home on 7/16/17, and observed and assessed the safety of the SS with no concerns noted, which was reflected in the progress notes. It was learned on the date of SC's death, MGF was home, and SM and SF were there visiting; MGM was home for part of the day, but not at the time of the event. MGF reported the day of the incident, it was very warm, so the CHN were outside playing in a kiddie pool. SC was energetic the entire day and acting normally. At 2:30PM, MGF laid SC down for a nap. MGF reported he checked on SC about one hour later, and SC lifted his head and said, "Poppa." Around 4PM, MGF sent SM to wake SC. Shortly thereafter, MGF heard SM scream. MGF reported he went into the room and found SC not breathing and with blue lips. MGF stated he began performing CPR and called 911; EMS arrived soon after and transported SC to the hospital. MGF recalled SC "felt hot" when he was tending to him in the room. SC had been sleeping in MGF's bed on top of a comforter. MGM explained she had been at the home during the morning, but left in the early afternoon; she was not present when SC was found in distress. Both grandparents reported SC was otherwise healthy, had no preexisting medical conditions and was up to date medically.

SLCDSS interviewed SF and SM, and confirmed he was not the BF to the SS; however, SF helped raise SS most of his life. SLCDSS was provided with the name of SS's BF. It was learned the CHN had resided with MGM and MGF under Article 6 custody for the past 2 months, due to SM and SF's ongoing drug use. SF explained he and SM were allowed supervised visitation at MGM and MGF's home, 7 days a week between 8AM and 8PM, as agreed upon. SF and SM had no concerns regarding the care of the CHN in the grandparents' home. SF reported he had another CH, but had not had any contact with him in six years. SM and SF's account of events on the date of SC's death were consistent with MGM and MGF's. SF reported he and SM were visiting on that day, and all spent most of the day outside; the CHN were playing in a kiddie pool, and he was fixing four-wheelers in the garage when SC was found not breathing. SF and SM reported SC was acting normally prior to that. SM reported an ordinary day where the CHN were playing outside, and at one point MGF had asked her to wake SC up from his nap. SM reported she did, and this is when she found him "gasping for air" and MGF began CPR; a few minutes later SC stopped breathing.

During the investigation, concerns were brought to SLCDSS' attention that SM and SF were engaging in drug use again. SLCDSS referred both parents to counseling services, but both declined. Both MGM and MGF were aware SM and SF may have been using, and would be sure SS would not be allowed around them if they appeared under the influence.

Throughout the investigation, SLCDSS contacted numerous collateral sources. Home visits were made and interviews with family members were thorough. At the close of the investigation, the SS was deemed safe. All parties were adamant that SC had access to water during the day of his death, and did not appear to be in any distress prior to being laid down for his nap. There were no criminal charges filed against the parents or grandparents. SLCDSS found no evidence to support the allegations, and appropriately UNF the report. The family was referred to appropriate services prior to case closure.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From a 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
Comments: This fatality investigation was conducted by the St. Lawrence County Multi-Disciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: St. Lawrence County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042662 - Deceased Child, Male, 2 Yrs	042664 - Grandparent, Male, 50 Year(s)	DOA / Fatality	Unsubstantiated
042662 - Deceased Child, Male, 2 Yrs	042664 - Grandparent, Male, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
042662 - Deceased Child, Male, 2 Yrs	042666 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
042662 - Deceased Child, Male, 2 Yrs	042666 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
042662 - Deceased Child, Male, 2 Yrs	042667 - Father, Male, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
042662 - Deceased Child, Male, 2 Yrs	042667 - Father, Male, 32 Year(s)	DOA / Fatality	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:

SLCDSS contacted an array of collateral sources throughout the investigation. The record did not reflect whether or not the CW attempted to interview the BF of the SS. SLCDSS did not make efforts to assess or intervew the SC's half-sibling.

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?	☐	☒	☐	☐
Explain as necessary: The SS was not removed as a result of this fatality report or for reasons unrelated, but remained in Article 6 placement with the grandparents due to concerns regarding SM and SF's drug use.				

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Appropriate services were offered to address the family's grief and trauma due to SC's death. Based on SM and SF's history of drug use, and CW's suspicions that they had begun using again after SC died, CW offered a referral to treatment on several occasions throughout the investigation. Both SM and SF declined the referrals.

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:
SLCDSS offered a referral for SS to attend grief/trauma services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief and trauma services were offered to all family members. At first, the family accepted the referrals, but later chose independent providers for services. SM and SF denied a need for substance abuse treatment.

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?	No
Was the child ever placed outside of the home prior to the death?	Yes
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?	No

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)
06/16/2016	Deceased Child, Male, 1 Years	Father, Male, 30 Years	Parents Drug / Alcohol Misuse	Indicated	Yes
	Deceased Child, Male, 1 Years	Mother, Female, 21 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 2 Years	Grandparent, Male, 48 Years	Lack of Supervision	Indicated	
	Sibling, Male, 2 Years	Grandparent, Female, 49 Years	Lack of Supervision	Indicated	
	Deceased Child, Male, 1 Years	Father, Male, 30 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 2 Years	Father, Male, 30 Years	Parents Drug / Alcohol Misuse	Indicated	

Deceased Child, Male, 1 Years	Mother, Female, 21 Years	Lack of Supervision	Indicated
Sibling, Male, 2 Years	Mother, Female, 21 Years	Inadequate Guardianship	Indicated
Sibling, Male, 2 Years	Mother, Female, 21 Years	Lack of Supervision	Indicated
Deceased Child, Male, 1 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Indicated
Sibling, Male, 2 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Indicated
Sibling, Male, 2 Years	Grandparent, Female, 49 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 1 Years	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Indicated
Deceased Child, Male, 1 Years	Father, Male, 30 Years	Lack of Supervision	Indicated
Sibling, Male, 2 Years	Father, Male, 30 Years	Inadequate Guardianship	Indicated
Sibling, Male, 2 Years	Father, Male, 30 Years	Lack of Supervision	Indicated
Sibling, Male, 2 Years	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Indicated
Deceased Child, Male, 1 Years	Grandparent, Male, 48 Years	Lack of Supervision	Indicated
Deceased Child, Male, 1 Years	Grandparent, Female, 49 Years	Lack of Supervision	Indicated
Deceased Child, Male, 1 Years	Grandparent, Female, 49 Years	Inadequate Guardianship	Indicated

Report Summary:
This report was received with concerns SM and SF were using drugs daily while caring for SC and SS, and therefore not providing adequate supervision of the CHN. The report further stated SM and SF used drugs in front of the CHN, and the grandparents would leave the CHN in the parents' care knowing they were under the influence. There was also a concern SS was able to go outside unattended, climb into the family car, and somehow got it to start moving backwards in the driveway; MGM saw this happening and stopped the vehicle.

Determination: Indicated | **Date of Determination:** 08/15/2016

Basis for Determination:
Jefferson County Department of Social Services (JCDSS) investigated; that is where the family previously resided. JCDSS interviewed family members, collaterals, and completed home visits. Assessments were completed timely detailed. Safety concerns were addressed and the CHN were placed in respite care until the home could be cleaned and free of safety hazards. JCDSS found both SM and SF were engaging in the use of methamphetamine. A Neglect Petition was filed against SM, SF, MGM, and MGF, and Article 10 custody was granted to the grandparents; SM and SF had supervised visitation. The family was ordered to engaged in services. CPS opened a services case, which remained open until 6/15/17.

OCFS Review Results:
JCDSS gathered a wealth of information to appropriately determine the case and open for services. Immediate safety concerns were addressed promptly and adequately. Case supervision was documented in detail. The record did not reflect whether the BF of the SS was ever contacted, or if a Notice of Existence was mailed. Many progress notes were entered one month or later after the event date.

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

Issue:

Adequacy of face-to-face contacts with the child and/or childs parents or guardians

Summary:

The record did not reflect whether the BF of the SS was ever contacted, or if contact was attempted.

Legal Reference:

432.1 (o)

Action:

JCDSS will make efforts to interview the BFs of all children named on a report.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Many progress notes were entered one month or later after the event date.

Legal Reference:

18 NYCRR 428.5

Action:

JCDSS will enter progress notes contemporaneously after events occur.

Issue:

Failure to provide notice of report

Summary:

A Notice of Existence Letter was not mailed/delivered to the BF of the SS.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

JCDSS will mail/deliver Notice of Existence letters to absent parents of a child named on a report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/02/2016	Sibling, Male, 2 Years	Father, Male, 30 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Male, 2 Years	Father, Male, 30 Years	Lacerations / Bruises / Welts	Indicated	
	Deceased Child, Male, 1 Years	Father, Male, 30 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Sibling, Male, 2 Years	Grandparent, Female, 48 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 1 Years	Grandparent, Female, 48 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 1 Years	Father, Male, 30 Years	Lack of Supervision	Indicated	
	Sibling, Male, 2 Years	Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Sibling, Male, 2 Years	Mother, Female, 21 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 1 Years	Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Indicated	

Deceased Child, Male, 1 Years	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 2 Years	Grandparent, Male, 48 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Male, 2 Years	Father, Male, 30 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Male, 2 Years	Father, Male, 30 Years	Lack of Supervision	Indicated
Deceased Child, Male, 1 Years	Father, Male, 30 Years	Inadequate Guardianship	Indicated
Sibling, Male, 2 Years	Grandparent, Female, 48 Years	Inadequate Food / Clothing / Shelter	Indicated
Deceased Child, Male, 1 Years	Father, Male, 30 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 2 Years	Mother, Female, 21 Years	Excessive Corporal Punishment	Indicated
Deceased Child, Male, 1 Years	Mother, Female, 21 Years	Lacerations / Bruises / Welts	Indicated
Deceased Child, Male, 1 Years	Mother, Female, 21 Years	Lack of Supervision	Indicated
Sibling, Male, 2 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 1 Years	Grandparent, Male, 48 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Male, 2 Years	Father, Male, 30 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 2 Years	Grandparent, Female, 48 Years	Lacerations / Bruises / Welts	Indicated
Deceased Child, Male, 1 Years	Grandparent, Female, 48 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Male, 2 Years	Mother, Female, 21 Years	Lacerations / Bruises / Welts	Indicated
Sibling, Male, 2 Years	Mother, Female, 21 Years	Lack of Supervision	Indicated
Deceased Child, Male, 1 Years	Mother, Female, 21 Years	Inadequate Guardianship	Indicated
Sibling, Male, 2 Years	Grandparent, Male, 48 Years	Lacerations / Bruises / Welts	Indicated
Deceased Child, Male, 1 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Indicated

Report Summary:
JCDSS received a report with concerns SM and SF were impaired by drugs on a regular basis and SC and SS were not appropriately cared for as a result. There were further concerns the home was dirty and the CHN had access to cleaning supplies and other hazardous items. Further, the report alleged the CHN had bite marks on their bodies, and the grandparents were aware of these concerns but failed to intervene.

Determination: Unfounded	**Date of Determination:** 04/22/2016

Basis for Determination:
JCDSS interviewed SM, SF, MGM, MGF, BF, collaterals, and completed home visits. The CHN were observed and allegations surrounding drug use and bite marks were discussed. There were no concerns regarding the immediate safety of the CHN throughout the investigation. The parents did not appear under the influence at any time during the investigation. JCDSS had evidence to substantiate the allegations due to SM biting SS, and SF not supervising the CHN appropriately, which led to SS biting SC repeatedly. JCDSS referred SM and SF to parenting classes prior to closing the case.

OCFS Review Results:
JCDSS did not address all allegations received in the report. Notices of Existence were not mailed/delivered within the required time frame. All appropriate services were not offered to the family prior to the closing of the case. The case record does not reflect if unfounded CPS history was reviewed. JCDSS did not educate the parents surrounding safe sleep, despite being informed the parents co-slept with SC every night.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
JCDSS did not address all allegations received in the report, including the concerns regarding the CHN having access to toxic materials and putting them in their mouths, an incident involving lack of supervision at a campsite, and a concern SC had choked in the past and stopped breathing, but SM failed to bring him for medical attention.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
JCDSS will fully explore all allegations received in a report, prior to making a determination.

Issue:
Failure to provide notice of report
Summary:
Notices of Existence were not mailed/delivered within the required time frame.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
JCDSS will mail/deliver NOEs within the 7-day required time frame.

Issue:
Failure to Offer Services
Summary:
All appropriate services were not offered to the family prior to the closing of the case. This was the third report with concerns of possible drug use by the parents. A substance evaluation was not offered, nor were services related to such. This is also the third report where home conditions were hazardous. Homemaking skills or related services were not offered.
Legal Reference:
SSL 424(10); NYCRR 428.6
Action:
JCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Failure to provide safe sleep education/information
Summary:

JCDSS did not educate the parents surrounding safe sleep. Additionally, JCDSS was informed informed the parents co-slept with SC every night.

Legal Reference:

13-OCFS-ADM-02

Action:

JCDSS 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/23/2015	Sibling, Male, 1 Years	Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unfounded	Yes
	Sibling, Male, 1 Years	Mother, Female, 20 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 5 Months	Mother, Female, 20 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Deceased Child, Male, 5 Months	Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Deceased Child, Male, 5 Months	Mother, Female, 20 Years	Inadequate Guardianship	Unfounded	

Report Summary:

JCDSS received a report with concerns SM was using drugs in the presence of SC and SS, and could not appropriately care for them as a result. Further concerns were the CHN were not being bathed and SM often ran out of formula for SC, leaving him hungry. The report also alleged the grandparents were aware and not intervening.

Determination: Unfounded | **Date of Determination:** 02/02/2016

Basis for Determination:

JCDSS interviewed SM and SF, collaterals, and completed home visits. The CHN were observed and safe sleep was discussed. There were no concerns regarding the safety of the CHN throughout the investigation. It was determined SM and SF did not reside with the grandparents, as was originally thought. JCDSS found no evidence of drug use in the home and found the CHN had adequate supplies. The parents did not appear under the influence at any time during the investigation.

OCFS Review Results:

The case record did not reflect if JCDSS made attempts to speak with the BF of the SS. Only SM was given a Notice of Existence letter, and it was not mailed/delivered within the 7-day required time frame. Many progress notes were entered several months after their event dates. The case record does not reflect that unfounded CPS history was reviewed. JCDSS did not offer the family services prior to case closure. It is unclear why JCDSS did not name the grandparents as subjects, but rather listed them as "reported in error" in Connections, despite concerns in the report narrative that they were not intervening to protect the CHN.

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

Issue:

Adequacy of face-to-face contacts with the child and/or childs parents or guardians

Summary:

The case record did not reflect if JCDSS made attempts to speak with the BF of the SS.

Legal Reference:

432.1 (o)

Action:
JCDSS will make efforts to interview the parents of all children named on a report.

Issue:
Failure to provide notice of report
Summary:
Only SM was given a Notice of Existence letter, and it was not mailed/delivered within the 7-day required time frame.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
JCDSS will mail/deliver Notice of Existence letters to all individuals named on a report within the 7-day required time frame.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Many progress notes were entered several months after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
JCDSS will enter progress notes contemporaneously after events occur.

Issue:
Failure to Offer Services
Summary:
A thorough assessment of possible needed services was not completed; JCDSS did not offer the family any services prior to case closure.
Legal Reference:
SSL 424(10); NYCRR 428.6
Action:
JCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Appropriateness of allegation determination
Summary:
The report was received with allegations against MGM and MGF. The CW interviewed both and found they had no concerns for SM or PS, and there was indication they provided some care taking responsibilities to the CHN; however, rather than making the appropriate determination, JCDSS changed the grandparents' role to reported in error.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
JCDSS will appropriately determine all allegations against subjects in reports.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/11/2014	Sibling, Male, 9 Months	Father, Male, 29 Years	Inadequate Guardianship	Unfounded	No

Sibling, Male, 9 Months	Mother, Female, 20 Years	Inadequate Food / Clothing / Shelter	Unfounded
Sibling, Male, 9 Months	Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unfounded
Sibling, Male, 9 Months	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Unfounded
Sibling, Male, 9 Months	Mother, Female, 20 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 9 Months	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unfounded

Report Summary:
JCDSS received a report with concerns SM and SF engaged in drug and alcohol use when caring for the then 10-month-old SS. The report also alleged SF dropped SS on several occasions due to being impaired. Further, the report alleged the home was dirty and SS was obese.

Determination: Unfounded | **Date of Determination:** 02/05/2015

Basis for Determination:
JCDSS investigated all allegations, interviewed SM and SF, observed the home environment and the CHN on more than one occasion, and noted no concerns. SC was born during this investigation and added to the case. The parents denied all allegations. Collateral sources were contacted. The pediatrician did not note any concerns regarding SS's weight. JCDSS made efforts to speak with the BF of the SS. Safe sleep was observed and discussed regarding both CHN. JCDSS unsubstantiated the allegations and closed the case.

OCFS Review Results:
This investigation met all statutory requirements; however, JCDSS did not offer the family services prior to closing the case. Although no immediate safety concerns were present at the time, the CW noted the parents had possible developmental delays, SM was pregnant, the SS was overweight and needed portioned meals, and the home was messy. Services could have been beneficial to the family to assist with on-going needs.

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

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

8/29/04 - A report was IND against MGF for IG re: SM as a child and her siblings.
6/10/08 - A report was UNF against MGF for IG.
11/21/08 - A report was UNF against MGF for IG.
2/2/09 - A report was IND against MGF for IG re: MU as a child.
10/4/11 - A report was IND against MGF for IF/C/S and IG re: SM as a child.

There is no CPS history more than three years prior to the fatality for SM or SF.

Known CPS History Outside of NYS

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

Preventive Services History

A preventive services case was opened through Jefferson County Department of Social Services (where the family previously resided) on 6/17/16 due to SM and SF engaging in drug use, not supervising SC and SS, and an unsafe home environment. The CHN were placed in respite care until MGM and MGF were awarded Article 10 custody on 7/5/16; SM and SF were ordered to leave the home. SM and SF were ordered to participate in substance abuse and MH counseling, as

well as parenting classes. SC and SS were ordered to be evaluated by Early Intervention. MGM and MGF were also involved with service planning, as they allowed their home to become deplorable while the CHN were living there. The services case remained open until 6/15/17. The case was closed due to the CHN achieving permanency in the custody of their grandparents, and the family moving to St. Lawrence County.

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/07/2016	Adjudicated Neglected	Adjourned in Contemplation of Dismissal (ACD)
Respondent:	042666 Mother Female 23 Year(s)	
Comments:	A Neglect Petition was filed on 7/7/16 against SM, SF, MGF, and MGM, on behalf of SC and SS, due to concerns regarding the parents drug use, deplorable home conditions, and the parents and grandparents' failure to appropriately supervise the CHN. The CHN were placed in Article 10 Custody of MGF and MGM, and the parents were allowed supervised visitation. SM and SF were ordered to attend services. The family eventually moved to St. Lawrence County. The SC and SS's tracks were closed, and Article 6 joint custody was granted to the grandparents and the parents; primary residence of the CHN would be with the grandparents.	

Have any Orders of Protection been issued? Yes	
From: 07/07/2016	**To:** Unknown
Explain: Refrain From Orders of Protection was put into place against SM and SF after the CHN were removed, allowing only supervised visitation between the parents and the CHN.	

Recommended Action(s)

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

Action:	Jefferson County Department of Social Services (JCDSS) completed an investigation involving this family in February 2015. Although there were no immediate safety concerns at the time of that report, JCDSS did not offer the family referrals or information regarding resources/services prior to case closure. OCFS is recommending prior to closing investigations, information and referrals be provided to families for any services available in their communities that may be appropriate based upon their individual circumstances and needs.

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