Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-19-016

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

Issue Date: Sep 24, 2019

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased **Jurisdiction:** Oneida **Date of Death:** 04/03/2019
Age: 5 month(s) **Gender:** Male **Initial Date OCFS Notified:** 04/03/2019

Presenting Information

An SCR report was received that stated the mother took the infant for medical care on 4/2/19 and he was diagnosed with a respiratory condition and prescribed medication. The mother administered the medication as directed and she reported his symptoms were not improving and she planned on returning to the doctor for further examination. While the mother was waiting for transportation to the doctor, she was holding the infant in her arms and he became limp. The mother called 911 and EMS arrived at the home. The infant was transported to the ER by ambulance. At the ER the infant was given medication and his heart began beating again. The infant then passed away. The circumstances that caused the death were unknown and the mother was named as an alleged subject in his death.

Executive Summary

This report concerns the death of the 5-month-old male child. Oneida County Department of Social Services (OCDSS) received an SCR report regarding the death on 4/3/19. At the time of his death, there was an open CPS investigation with concerns about the infant's weight and growth and also the mother's possible drug use. The mother, infant and sibling also had an open Preventive Services case at the time of the fatality. The mother had a history of drug misuse and was compliant with drug treatment and ongoing drug court proceedings at the time of this writing. The mother was regularly drug tested and was negative for all substances other than prescribed medication.

On the morning of 4/3/19, the mother was home with the infant and sibling. The mother took the infant to the doctor on 4/2/19 and he was diagnosed with a respiratory issue and prescribed medication. The mother administered the medication as prescribed and his symptoms improved. The infant had not been acting differently in the time leading to his death and was reportedly cheerful. In the late morning hours of 4/3/19, the infant suddenly became unresponsive while in the mother's arms and she contacted 911. First responders transported the infant to the ER and resuscitation efforts were futile.

The ME performed an autopsy and the final report was not completed at the time of this writing. The preliminary report revealed the infant had no trauma to his body. The final autopsy was pending the toxicology, histopathology, viral/bacterial cultures, metabolic screen and a neuropathology evaluation.

LE investigated the death and took several items from the home into evidence, including the medication prescribed for the infant. There was no documentation in the case record that LE found criminality in the death of the infant.

OCDSS learned the infant lived in the home with his 2-year-old sibling and they assessed the safety of the sibling throughout the investigation. OCDSS also discovered the mother had two other children that were not living with her. The mother had not had contact with the two children for a period of several years and they were in the custody of relatives. One of the children resided with his father and was seen and assessed to be safe. The father reported the mother has visitation as agreed upon and it is supervised. The father arranged for the mother to have a visit with the child after the infant's death. The case record indicates the other sibling lived with a paternal grandmother, but there is no documentation of a safety assessment of the child.

OCDSS had not yet made a determination of the allegations associated with the infant's death at the time of this writing. The mother continued to receive Preventive Services and additionally grief services and burial assistance were provided.

PIP Requirement

OCDSS will submit a PIP to the Syracuse 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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The CPS investigation remained open at the time of this writing and a determination had not been made.

Was the decision to close the case appropriate? N/A

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

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

Explain:
The CPS investigation and Preventive Services case remained open at the time of this writing.

Required Actions Related to the Fatality

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

Issue:	Review of CPS History
Summary:	There is no documentation in the fatality investigation that a CPS history search was done.
Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	OCDSS will review all prior CPS history within regulatory required timeframes.
Issue:	Contact/Information From Reporting/Collateral Source

Summary:	The mother's boyfriend was present during the fatal incident and he was never interviewed by OCDSS.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	OCDSS will make efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/03/2019 **Time of Death:** 12:24 PM

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

County where fatality incident occurred: Oneida
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 alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: awake in mother's arms

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	5 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Other Household 1	Father	No Role	Male	50 Year(s)

LDSS Response

On 4/3/19, OCDSS received a report regarding the death of the infant. OCDSS contacted the source, DA and ME and also coordinated their investigation with LE. A case conference was held with other agency personnel to discuss the mother's

ongoing involvement with her service providers and the functioning of the family since OCDSS preventive services were opened. No concerns regarding the mother's care of the children were noted.

OCDSS interviewed the mother regarding the timeframe leading up to the infant's death. The mother reported that she brought the infant to an urgent care facility on 4/2/19 and he was diagnosed with a respiratory condition and prescribed medication. The infant was given the first dose of medication at the doctor and the mother gave him the next dose at around 8:30AM on 4/3/19. The mother reported the infant woke at 2:00AM on 4/3/19, and she gave him the prescribed breathing treatment at that time and he was breathing better. At 5:00AM the infant woke for the day and the mother said his breathing improved and he was behaving fine. The mother reported taking a shower and then at 10:40AM she was holding the child and he went limp. The mother called 911 and then her boyfriend stopped by the home and administered CPR. The first responders then arrived and transported the infant to the ER. The ER staff told the mother the infant went into cardiac arrest at the ER, as a result of the medication he was prescribed. The mother was not given any further information.

The mother's family came to her home and picked up the sibling after the ambulance took the infant to the ER. The mother and sibling went to stay with the maternal grandmother temporarily. OCDSS assessed the safety of the sibling at the maternal grandmother's home the same day the report was received.

OCDSS requested and reviewed the infant's medical records. ER records from the incident stated the infant arrived at the hospital without a pulse. The infant was intubated and CPR was given, in addition to medication. The infant's pulse returned and CPR was stopped. The infant lost his pulse a short time later and CPR was again initiated. The infant was unable to be resuscitated. The pediatrician's office reported the infant was seen on 2/20/19, and they had no concerns. The infant was reportedly a healthy weight and in good overall health. He had a 6-month well baby exam scheduled for 4/23/19. The pediatrician was surprised about the death. OCDSS spoke with the visiting nurse that worked with the infant since his birth. The nurse reported the infant was successfully discharged from the program at the end of February 2019, and he had gained weight steadily, was eating well and healthy. She had no concerns for the mother's care of the infant.

OCDSS spoke with the father and he stated the mother told him the infant recently had a respiratory infection and that she believed he died from a reaction to the medication he was prescribed to treat the issue. The father had no other information regarding the health of the infant and stated he had no current concerns regarding the mother.

The investigation remained open at the time of this writing, as did the preventive case. The mother continued to attend substance abuse treatment and had begun grief counseling.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051141 - Deceased Child, Male, 5 Mons	051142 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Pending
051141 - Deceased Child, Male, 5 Mons	051142 - Mother, Female, 30 Year(s)	DOA / Fatality	Pending

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 mother's boyfriend arrived at the home when the infant was in distress and performed CPR, however he was not interviewed.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
Although the mother told OCDSS the sibling did not want to sleep in his room because he did not want to keep seeing the infant's things, no service referrals were made for the sibling.

Placement Activities in Response to the Fatality Investigation

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

Legal Activity Related to the Fatality

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

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:
The mother was engaged in substance abuse treatment services before the death of the infant and continued these services. The mother was also attending drug court previous to the fatality and continued participating. The mother began grief counseling.

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? N/A
Explain:
There is no documentation that the surviving sibling required services in response to the fatality and there is no documentation services were offered.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was provided burial assistance and referred to grief counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? Yes
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/13/2019	Deceased Child, Male, 2 Months	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 2 Months	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 23 Months	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 23 Months	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Male, 2 Months	Mother, Female, 29 Years	Malnutrition / Failure to Thrive	Substantiated	

Report Summary:
An SCR report was received that alleged the mother frequently smoked marijuana in the presence of the 3-month-old child and her other children. As a result, the child had a positive toxicology for marijuana, was underweight for his age and had failure to thrive.

Report Determination: Indicated | **Date of Determination:** 03/09/2019

Basis for Determination:
OCDSS found that although the mother denied using marijuana, the infant was exposed to marijuana as he tested positive for it and there was no other explanation. The mother did not follow the feeding guidance from the pediatrician until CPS was involved, causing slow weight gain for the infant. As a result of her failure to follow through with the infant's feeding needs and medical appointments, OCDSS filed a neglect petition and the mother made an admission to neglect in Family Court on 3/7/19. The Preventive Services case with a CPS monitor continued at the conclusion of the investigation.

OCFS Review Results:
The concerns in the report and that arose were not addressed. While the infant was hospitalized, staff reported the mother

was not frequently there with the child, as was required by the hospital. There was no home visit documented when the child was discharged. There was no discussion with the mother about her plan for future medical care for the child or coordination with his pediatrician. There was also no discussion with the mother about her two children that do not reside with her.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The hospital staff expressed concerns to OCDSS regarding the mother's presence at the hospital and these concerns were not discussed with the mother during the investigation. OCDSS did not visit the home to assess the safety of the children and provisions in the home. OCDSS did not discuss the infant's ongoing medical care with the mother or the pediatrician.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
OCDSS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any ongoing concerns when it is necessary to remain involved.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/27/2018	Deceased Child, Male, 9 Days	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Deceased Child, Male, 9 Days	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 9 Days	Mother, Female, 29 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 9 Days	Mother, Female, 29 Years	Malnutrition / Failure to Thrive	Substantiated	
	Sibling, Male, 20 Months	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 20 Months	Mother, Female, 29 Years	Lack of Supervision	Substantiated	

Report Summary:
An SCR report was received that alleged the mother fell asleep while feeding the 9-day-old baby. The baby rolled out of the mother's arms and down her legs landing on her feet. It was not the first time the mother fell asleep while feeding the baby. Mother was not able to provide adequate care for baby. A subsequent report was received that alleged the mother was failing to bring the infant for follow up medical appointments and as a result he was diagnosed with failure to thrive.

Report Determination: Indicated | **Date of Determination:** 02/11/2019

Basis for Determination:
On 10/27/18 the infant fell out of his mother's arm after she fell asleep while feeding him. The infant was still in the hospital at the time due to withdrawal from methadone after birth. The infant was diagnosed as failure to thrive and the mother failed to bring him to medical appointments. The mother was not giving the infant supplemental formula as prescribed. A subsequent SCR report was received and investigated concurrently.

OCFS Review Results:
Several home visits were made to speak to the mother and see the sibling and infant. The mother was not cooperative and although OCDSS made contact on multiple occasions, the safety of the infant was not adequately assessed and his body

was not observed unclothed. There was also a delay in contacting medical providers that may have offered pertinent information regarding the immediate safety and well being of the infant. It would have been appropriate for OCDSS to facilitate a medical exam of the infant at the onset of the investigation. The casework was not commensurate with the case circumstances.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
Although several home visits were made and the mother and children were seen, the quality of the contacts was lacking. The safety and well being of the infant was not adequately assessed given the nature of the allegations. OCDSS delayed 3 months in contacting the pediatrician treating the infant, despite the serious medical concerns. OCDSS contacted the doctor after receiving another SCR report.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
OCDSS will fully explore and document the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child. Further, OCDSS will make collateral and familial contacts to fully address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns as warranted.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/25/2018	Sibling, Male, 18 Months	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 18 Months	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report was received that alleged the mother become impaired by heroin on a regular basis while she was the sole caretaker of the sibling. Mother invited strangers into the home and they used drugs together.

Report Determination: Unfounded **Date of Determination:** 10/18/2018

Basis for Determination:
During the investigation the mother was observed to be sober at all home visits and denied any current drug use. The mother was attending substance treatment and testing positive for her prescribed medication. There was no evidence on drug misuse uncovered after speaking with collaterals.

OCFS Review Results:
All adults listed were interviewed and multiple collateral contacts made. CPS history search was not completed timely.

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

Issue:
Review of CPS History

Summary:
The CPS history search was completed on 7/31/18 and the SCR report was received on 7/25/18.

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

Action:
OCDSS will review all prior CPS history within regulatory required timeframes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/06/2018	Sibling, Male, 1 Years	Father, Male, 49 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 1 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Years	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report was received which alleged the mother abused heroin while being sole caretaker of one-year-old child. Mother and father got into physical dispute in presence of child. No food in house because mother spends food stamp money on drugs.

Report Determination: Indicated | **Date of Determination:** 06/22/2018

Basis for Determination:
The father hit the mother in the face on 4/5/18 and was arrested. There was an order of protection in place against the father prohibiting contact with the mother. The mother was involved in ongoing criminal court as the result of overdosing while she was the sole caretaker for the sibling. The mother was not attending drug treatment as scheduled, but her drug tests results were only positive for her prescribed medication. OCDSS found there to be food in the home and the mother sober during home visits. There was a subsequent report received and consolidated with this investigation.

OCFS Review Results:
OCDSS consulted the case planner and previous caseworkers regarding the mother's history with drug use. Legal was consulted as the mother was not consistently attending outpatient treatment that was court ordered due to previous criminal charges. The casework was commensurate with the circumstances and the caseworker contacted several collaterals and all denied concerns the mother was using drugs. The father was incarcerated throughout the investigation.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/28/2017	Sibling, Male, 5 Months	Father, Male, 48 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 5 Months	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 5 Months	Mother, Female, 28 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 5 Months	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 5 Months	Mother, Female, 28 Years	Other	Unsubstantiated	
	Sibling, Male, 5 Months	Father, Male, 48 Years	Other	Unsubstantiated	
	Sibling, Male, 5 Months	Grandparent, Female, 49 Years	Other	Unsubstantiated	

Report Summary:
An SCR report was received that alleged the mother was addicted to heroin and used the drug while caring for the sibling. The mother had reportedly overdosed while in front of the child and he was unsupervised. The mother was found by an unrelated home member. On 6/27/17 the mother and father physically assaulted each other while the sibling was present. The parents had a history of domestic violence. There was additionally a court ordered investigation as the maternal grandmother filed for custody of the sibling. There were two subsequent reports received and they were consolidated into the investigation.

Report Determination: Indicated | **Date of Determination:** 09/29/2017

Basis for Determination:
The mother disclosed that on 6/27/17, she was assaulted by the father in the presence of the sibling. At the time of the incident the mother had a stay away order of protection against the father and he was aware of the order. The father was arrested and incarcerated. The father reported that the mother physically assaulted him on 6/27/17 because he would not get her drugs. On 7/29/17, the mother was found unresponsive on the bathroom floor as the result of a heroin overdose, while the sibling was unattended in another room of the home. LE reported the mother was administered 8 doses of Narcan to reverse the overdose. The maternal grandmother was granted custody of the sibling.

OCFS Review Results:
OCDSS failed to consult legal after the mother overdosed while alone and caring for the sibling. Although the maternal grandmother was granted custody of the sibling, no actions were taken to provide oversight to the mother. Notice of existence letters were not issued for the two subsequent reports.

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

Issue:
Failure to provide notice of report
Summary:
OCDSS did not issue notice of existence letters for the two subsequent reports that were consolidated with the initial report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:
Assessment as to need for Family Court Action
Summary:
The record did not reflect a legal consultation took place, despite information the mother overdosed while she was the sole caretaker for the 5-month-old sibling.
Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)
Action:
OCDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/17/2017	Sibling, Male, 1 Months	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report was received that alleged the mother and father had a verbal argument that became physical, in front of the sibling. The father attempted to get the mother out of the home and she kicked in the door and bit the father.

Report Determination: Unfounded | **Date of Determination:** 05/23/2017

Basis for Determination:
The mother and father both disclosed having a physical altercation but denied the sibling was present. The parent stated during the time of the incident the sibling was in a car with the maternal grandmother and she confirmed this was accurate. There were no further incidents during the investigation.

OCFS Review Results:
The father was arrested and the mother received an order of protection. The father left the home and the OCDSS continued to assess the safety of the sibling in the care of the mother. The risk assessment profile did not reflect the father's diagnosed mental illness.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The assessment did not accurately reflect the father's mental illness.

Legal Reference:
18 NYCRR 432.2(d)

Action:
OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/26/2017	Sibling, Male, 1 Days	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:
An SCR report was received that alleged the mother gave birth to the sibling and had a positive toxicology for marijuana. The sibling's toxicology results were pending.

Report Determination: Unfounded | **Date of Determination:** 03/28/2017

Basis for Determination:
The mother admitted to marijuana use during her pregnancy. The sibling did test positive for marijuana, but there was no evidence he was negatively impacted as a result. On 3/9/17, the mother again tested positive for marijuana, but denied she had used. The mother told OCDSS her neighbors were using it and she must have come into contact with it. There was no evidence the mother's marijuana use had an impact on the sibling. There was another SCR report made during the conclusion of the investigation and OCDSS continued to monitor the family during that investigation.

OCFS Review Results:
Several home visits were completed and safe sleep education provided. The adults listed on the report were provided letters notifying them of the report. Although the 7-day safety assessment was completed timely, the report indicated that safety factors exist, yet there are none checked on the form. There was little documented in the case record regarding the mother's other children that were previously removed and living with relatives. It was not clear whether or not the mother maintained contact with the children. The children were listed on the report and later identified by OCDSS as reported in error, but the documentation regarding this was insufficient.

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day safety assessment reflected there were safety factors, yet there were no safety factors selected in CONNECTIONS.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

OCDSS will complete all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

There is no documentation in the case record that OCDSS spoke with the mother about her two other children that were listed on the report. The RAP indicated the children were previously removed from her care and resided with relatives, but there is no documentation to indicate whether the mother had contact with them. There is also no explanation about why they were coded as reported in error.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

OCDSS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/19/2016	Other Child - cousin, Female, 1 Years	Aunt/Uncle, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	No
	Other Child - cousin, Female, 1 Years	Grandparent, Female, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 1 Years	Aunt/Uncle, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 1 Years	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

An SCR report was received that alleged the mother was abusing heroin while caring for her niece. The mother of the child was aware and continued to allow the mother to care for the niece.

Report Determination: Unfounded | **Date of Determination:** 10/17/2016

Basis for Determination:

The grandmother and aunt denied that the mother was ever left to care for her niece and denied that they would ever allow drug use in the home. The mother denied drug use and reported she was pregnant and maintaining her sobriety. The mother's drug test results from the doctor were negative. During home visits all the adults appeared to be sober. The niece's babysitter was contacted and confirmed that she cared for the child 5 days a week while the aunt worked.

OCFS Review Results:

The casework was commensurate with the case circumstances.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/12/2016	Sibling, Male, 5 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 5 Years	Other Adult - father of sibling, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report was received that alleged the mother was having contact with a sibling although the sibling's father was aware this was not permitted due to her drug use. The father continued to leave the sibling with his mother knowing she actively used heroin and was unable to care for him.

Report Determination: Unfounded | **Date of Determination:** 09/09/2016

Basis for Determination:
The mother was in recovery from her heroin addiction and was visiting with the sibling as agreed upon by his father. The father would not allow the sibling to visit with the mother if he believed that she was impaired. The mother was pregnant and denied any drug use. The mother's drug screens from her doctor were negative. The sibling did not disclose any concerns during his interview.

OCFS Review Results:
The mother, father of the sibling and the sibling were interviewed. Collateral contacts were made and there was no evidence the mother was using drugs. The mother had visitation with the sibling at the father's discretion as he had obtained full custody in June of 2015 as the result of the mother's drug use at that time. There were no court orders prohibiting visitation with the mother and the sibling was assessed to be safe.

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

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

6/24/15-An SCR report with an allegation of IG substantiated against the mother and PD/AM unsubstantiated against the mother regarding the 7yo sibling.

10/22/14- An SCR report with an allegation of IG unsubstantiated against the mother regarding the 7yo sibling.

3/4/13- An SCR report with allegations of IG and PD/AM unsubstantiated against the mother regarding the 7yo sibling.

4/22/12- An SCR report with the allegation of IG unsubstantiated against the mother regarding the 7yo sibling and 10yo sibling.

11/7/11- An SCR report with the allegations of IG, IF/C/S, LS and PD/AM unsubstantiated against the mother regarding the 7yo and 10yo siblings.

Known CPS History Outside of NYS

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

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 02/03/2018

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 02/03/2018

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

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

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐

If not, how many days was it overdue?
The most recent FASP was completed 5 days after the due date.

Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐
Additional information, if necessary: Home visits and contact with service providers were regularly made during the open case. Service and medical providers were contacted regularly for updates.				

Preventive Services History

A preventive case was opened 2/3/18 because the mother and sibling were homeless. OCDSS worked with the mother to find and maintain housing and budgeting money to meet the household basic needs. The mother was provided a parent aide, outpatient drug treatment, housing services and mental health counseling. The sibling was provided with early intervention services. A protective program choice was added to the case 12/4/18 as the result of a neglect petition filed against the mother regarding the sibling and the newly born infant. During the court proceedings a stay away order of protection was issued against the father in favor of the mother and 2 children as the result of physically assaulting the mother. The father was granted supervised visits but rarely saw the children. An order of protection was also issued by the court against the mother in favor of the children. The order stated the mother would refrain from drug use and placing the children at risk of witnessing violence. Additionally the mother was ordered to supervise the children at all times and also to bring them for all scheduled medical appointments. In August of 2018 the mother also began attending drug court, as the result of criminal charges. The preventive services case with the protective program choice remained open at the time of this writing.

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:**

12/03/2018	Other, Specify	Order of Supervision
Respondent:	051142 Mother Female 30 Year(s)	
Comments:	A neglect petition was filed against the mother due to the infant's failure to thrive as the result of the mother's failure to follow up on recommended medical treatment. A derivative neglect petition was filed against the mother on behalf of the sibling. On 1/23/19 OCDSS filed an amended petition against the mother after the infant tested positive for marijuana when the mother took him to the hospital for medical treatment. On 3/7/19 the mother made an admission of using heroin during her pregnancy with the infant, causing him to suffer withdrawal symptoms. An order of supervision was put in place and expires on 3/7/2020.	

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** 06/30/2019
Explain: An Order of Protection was put in place in favor of the infant and sibling. It stated the mother would refrain from drug use and placing the children at risk of violence. It further stated the mother would not leave the children unsupervised and would bring them to all medical appointments and follow recommended care.	

Additional Local District Comments

Progress note entry has been completed to address issues noted in the open fatality investigation. OCDSS has provided mother and child(ren) preventive services since 12/19/17. Said services continued throughout the most recent investigations, i.e. ORDs 1/13/19 and 10/27/18. Good communication/coordination continued between CPS and Preventive workers. OCDSS continued to assess safety and risk by multiple contacts (day and evening); collateral contacts (visiting nurses, pediatrician's office, substance abuse providers, law enforcement records). Mother was not cooperative and had refused to undress the infant. To ensure child safety, legal consultation was sought resulting in OCDSS filing a Neglect Petition on 12/3/18. As further information was learned, an Amended Neglect Petition was filed on 1/23/19. Both CPS and Preventive case documentation, along with the Neglect Affidavits, support OCDSS' efforts. A supervisory review in ORD 7/25/18, documents that CPS history was reviewed and discussed (7/27/18). During ORD 6/27/17 investigation, a legal consultation did not occur as CPS assessed the child as safe after making multiple contacts with family members and collaterals. By case conclusion, the grandmother had court ordered custody of the child. Regarding reports, ORD 6/28/17, 3/17/17, 1/26/17, we concur that various technical aspects of the investigation were not completed. OCDSS has experienced staffing and retention issues. The assigned CPS workers on these investigations had hire dates either 5 or 11 months prior to assignment of said investigations. Noted issues have been addressed by OCDSS in subsequent and ongoing training for staff and within the supervisory conferences held at set intervals of an investigation. OCDSS continues to be committed to meeting the needs of our community members and ensuring best outcomes for children and families.

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