Child Fatality Report

Report Identification Number: AL-18-011

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

Issue Date: Dec 10, 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		

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Otsego
Gender: Male
Date of Death: 06/16/2018
Initial Date OCFS Notified: 06/16/2018

Presenting Information

An SCR report received on 6/16/18 alleged the SM gave birth to twins, Twin A and Twin B (SC) on 5/21/18. The twins were born prematurely. Twin A was deemed healthy enough to go home on 6/15/18, and was discharged, but died the next day. Twin B, was discharged on 6/4/18 and passed away on 6/15/18. There was no explanation for either death.

Executive Summary

This report concerns the death of the second twin, Twin B. (A separate report is being issued on Twin A.) The twins were born prematurely, and Twin B tested positive for marijuana at birth. The death was reported to the SCR on 06/16/18 and assigned to Otsego County Department of Social Services (OCDSS) for investigation. The investigation was held simultaneously with the investigation of the female twin, Twin A, who was pronounced deceased on 06/05/18, after the family found her unresponsive and not breathing.

After his birth, Twin B remained in the hospital for nearly 2 weeks and was discharged on 05/26/18. Around 4:15AM on 6/16/18, he was discovered to be lifeless while in the care of his parents and maternal grandparents.

Initially when questioned about Twin B's death, the family explained that the child was sleeping face up in his bassinet, in a safe sleep environment. However, as the investigation progressed, it was learned the mother had been co-sleeping with Twin B, nearly identical to how she was co-sleeping the night of Twin A's death.

OCDSS obtained information from collateral contacts including medical professionals, EMS, and the 12yo SS' mother and maternal grandmother. The mother of the 12yo SS had no concerns for the father's ability to care for her daughter. OCDSS observed the 12yo SS the following day, at her home, and there were no concerns noted for her safety. OCDSS and the family agreed to continue the safety plan established after the death of Twin A. The father was not to be the unsupervised around the 12yo SS while the investigation was underway, due to concerns of ongoing parental drug abuse and mental health concerns.

After thoroughly interviewing the family, it was learned both parents co-slept with the children since they were brought home from the hospital, despite having received education about safe sleep from the hospital and CPS both before and after the death of Twin A. During the investigation, the mother said she "may have suffocated" the children, while co-sleeping with them. Additional concerns were revealed by the father regarding the mother being under the influence of benzodiazepines, not prescribed to her, at the times the children were found unresponsive. Investigation into the deaths of both twins was still underway at the time of this writing, with no arrests made. Additionally, no Family Court petitions had been filed.

An autopsy was performed, listing the cause and manner of death to be undetermined for both children. The Coroner provided additional information that Twin B's death was caused by probable asphyxiation. The family was offered burial assistance, economic support, mental health counseling and bereavement services. Additionally, OCDSS offered the family drug addiction counseling.

PIP Requirement

In response to the citations which resulted from this review, OCDSS will submit a Program Improvement Plan (PIP) to the Regional Office (RO) which will identify what actions have been taken, or will be taken, to address these concerns. If a PIP is currently in place, the plan will be reviewed and revised as needed.

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?** No

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 report had not yet been determined at the time this Fatality Report was written.

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 case record included documentation of supervisory consults and extensive casework contact during the investigation.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Although the majority of the case notes were recorded timely, some progress notes were not entered contemporaneously during the investigation, and were documented up to 3 months after the event date.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be entered as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30-day Safety Assessment was completed inaccurately and was approved 2 days late. Although there was a Safety Plan in place that was referenced in the Safety Assessment, the appropriate Safety Decision was not selected.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances with regard to safety. Additionally, the Safety Assessments will be completed and approved within the required timeframes.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The Safety Decision consistently did not reflect the ongoing Safety Plan. The Safety Factor regarding a child's positive toxicology at birth should not have been selected as the 12yo SS was the only SS.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances with regard to safety. The Safety Assessments will be completed exclusively with regard to surviving children.
Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	A 24-hour Fatality Report was completed in Connections, but was not approved until 3 days after the due date.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	OCDSS must complete a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	A 30-day Fatality Report was not approved until 3 days after the due date.
Legal Reference:	CPS Program Manual, VIII, B.2, p.4
Action:	OCDSS must complete a 30-day Fatality Report within 30 days of receipt of a SCR report alleging the death of a child.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-hour Safety Assessment was not completed and approved until 2 days after the due date. The Safety Decision should have been #3, based on the on-going Safety Plan. Positive Toxicology should not have been selected for the SS.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	OCDSS will complete all assessments and accurately reflect the safety factors that are present, along with any Safety Plan that has been devised. The Safety Assessment will include information regarding surviving children exclusively.

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 06/16/2018 **Time of Death:** 05:54 AM

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

County where fatality incident occurred: Otsego
Was 911 or local emergency number called? Yes
Time of Call: 04:19 AM
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
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	56 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	56 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	21 Day(s)
Other Household 1	Other Adult - SS2's BM	No Role	Female	45 Year(s)
Other Household 1	Other Adult - SS2's MGM	No Role	Female	64 Year(s)
Other Household 1	Sibling	No Role	Female	12 Year(s)
Other Household 2	Father	Alleged Perpetrator	Male	44 Year(s)

LDSS Response

On 06/16/18, OCDSS received an SCR report regarding the death of the SC (Twin B) and his twin (Twin A). This report was subsequent to open investigations regarding the positive toxicology for the twins at birth, as well as, the death of Twin A, who died on 06/05/18.

OCDSS immediately contacted law enforcement, notified the DA and spoke to the source of the SCR report. Additionally, visits were made to the homes of both the parents and the 12yo surviving sibling. The mother of the 12yo sibling agreed to continue the safety plan for the father not to be around the sibling.

Although the 24-hour Fatality Report was completed accurately, the report was not approved until 3 days after the due date. Furthermore, the 24-hour Safety Assessment was not completed until 2 days after the due date.

OCDSS and law enforcement continued to investigate the death of Twin A jointly, and began the investigation into the death of Twin B. Initially, the family reported Twin B was found in his bassinette, unresponsive and not breathing, identical to how Twin A was discovered. During the investigation of Twin A's death, OCDSS observed the sleeping area of the twins, and noted that the bassinette met safe sleeping recommendations, and confirmed the parents had knowledge of safe sleep recommendations.

The family reported the mother found Twin B in the bassinette, face up, unresponsive and not breathing around 4:15AM. She alerted the father and called 911. The grandparents performed CPR until EMS responded to the scene, and transported Twin B to the hospital. Twin B was breathing upon hospital arrival; however, he was pronounced dead at 5:54AM.

During the investigation, the father appeared to be under the influence of drugs in an interaction with police. The following day, the family was questioned again regarding the incidents. The father stated that after the death of Twin A, the family discussed how they would explain the death, and planned to say that the children were sleeping in a bassinette.

According to the father, the night of Twin B's death, the mother wanted to hold the child, and the father allowed her to do so. The father stated that he woke to find the mother in the same position she was with Twin A, but there was a pillow between her and Twin B. The child's face was against a pillow that was pressed against the mother's chest, as she was sitting up yet slumped over the child. The father pushed the mother off the child and alerted the maternal grandmother. The father claimed the mother was abusing prescription drugs the nights of the children's deaths; He was providing her with the drugs.

The mother said she wasn't truthful during prior interviews, and said she "may have suffocated both babies." She explained that Twin B was on his back atop of a pillow on her chest, with her arm around him. The mother explained when she awoke, the pillow was between her and the child, and he was unresponsive and not breathing.

The grandparents did not provide additional information.

At the time this report was written, the investigations of both OCDSS and law enforcement remained open. A Family Court petition was under consideration, but had not been filed.

The Safety Assessments did not always accurately reflect the case record. Progress notes were not always entered contemporaneously to their event dates.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: The fatality investigation was assigned to a Multi-Disciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Otsego County Department of Social Services does not have an OCFS-approved Child Fatality Review Team at this time.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048351 - Deceased Child, Male, 1 Mons	048353 - Father, Male, 44 Year(s)	Inadequate Guardianship	Pending
048351 - Deceased Child, Male, 1 Mons	048353 - Father, Male, 44 Year(s)	DOA / Fatality	Pending
048351 - Deceased Child, Male, 1 Mons	048355 - Mother, Female, 27 Year(s)	DOA / Fatality	Pending
048351 - Deceased Child, Male, 1 Mons	048353 - Father, Male, 44 Year(s)	Parents Drug / Alcohol Misuse	Pending
048351 - Deceased Child, Male, 1 Mons	048368 - Grandparent, Male, 56 Year(s)	Inadequate Guardianship	Pending
048351 - Deceased Child, Male, 1 Mons	048369 - Grandparent, Female, 56 Year(s)	Inadequate Guardianship	Pending
048351 - Deceased Child, Male, 1 Mons	048368 - Grandparent, Male, 56 Year(s)	DOA / Fatality	Pending
048351 - Deceased Child, Male, 1 Mons	048355 - Mother, Female, 27 Year(s)	Parents Drug / Alcohol Misuse	Pending
048351 - Deceased Child, Male, 1 Mons	048355 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Pending
048360 - Sibling, Female, 21 Days	048355 - Mother, Female, 27 Year(s)	Parents Drug / Alcohol Misuse	Pending
048360 - Sibling, Female, 21 Days	048355 - Mother, Female, 27 Year(s)	DOA / Fatality	Pending
048360 - Sibling, Female, 21 Days	048353 - Father, Male, 44 Year(s)	Parents Drug / Alcohol Misuse	Pending
048360 - Sibling, Female, 21 Days	048369 - Grandparent, Female, 56 Year(s)	Inadequate Guardianship	Pending
048360 - Sibling, Female, 21 Days	048355 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Pending
048360 - Sibling, Female, 21 Days	048353 - Father, Male, 44 Year(s)	Inadequate Guardianship	Pending
048360 - Sibling, Female, 21 Days	048368 - Grandparent, Male, 56 Year(s)	DOA / Fatality	Pending
048360 - Sibling, Female, 21 Days	048353 - Father, Male, 44 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:

Although most of the progress notes were entered timely, some were not entered contemporaneously throughout the investigation. Some progress notes were entered approximately three months after the event date.

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:
The RAP was not yet required as the case was still on going at the time of this writing. OCDSS appropriately offered a multitude of services to the family. The maternal grandparents refused services. The father accepted mental health counseling. The family accepted and utilized funeral and burial services for Twin A, it was unknown at the time of this writing if they utilized the assistance for Twin B.

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:
Safety Assessments throughout the case indicate Safety Factors were present, yet this was not reflected in the Safety Decision. Although a Safety Plan was put into place, OCDSS did not select Safety Decision #3 as should have been done.

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	☐	☐	☐	☐	☐	☒	☐

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:
Counseling was offered to the SS and she declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS offered burial assistance, funeral assistance, trauma counseling, grief counseling, mental health counseling, bereavement counseling and made drug treatment referrals for the family.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

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)
06/05/2018	Sibling, Female, 21 Days	Mother, Female, 27 Years	Inadequate Guardianship	Pending	Yes
	Sibling, Female, 21 Days	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Pending	
	Deceased Child, Male, 21 Days	Mother, Female, 27 Years	Inadequate Guardianship	Pending	
	Deceased Child, Male, 21 Days	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Pending	
	Sibling, Female, 21 Days	Father, Male, 44 Years	Inadequate Guardianship	Pending	
	Sibling, Female, 21 Days	Father, Male, 44 Years	Parents Drug / Alcohol Misuse	Pending	
	Deceased Child, Male, 21 Days	Father, Male, 44 Years	Inadequate Guardianship	Pending	
	Deceased Child, Male, 21 Days	Father, Male, 44 Years	Parents Drug / Alcohol Misuse	Pending	
	Sibling, Female, 21 Days	Mother, Female, 27 Years	DOA / Fatality	Pending	
	Sibling, Female, 21 Days	Father, Male, 44 Years	DOA / Fatality	Pending	

Report Summary:
An SCR report received on 06/05/18 alleged twins were born prematurely on 05/15/18. The twins were discharged from the hospital on 06/04/18. The parents found Twin A unresponsive in her crib on 06/05/18 at about 6:30AM. The parents called EMS, who responded and transported the baby to the hospital. EMS arrived at the hospital at 7:28AM and Twin A was in cardiac arrest. Resuscitation efforts were unsuccessful. When the parents arrived at the hospital, they appeared to be on drugs. The father passed out at the ER and was hospitalized for an assessment of drug use.

Report Determination: Undetermined

OCFS Review Results:
OCDSS offered a multitude of services to the family and engaged them multiple times throughout the investigation. Although a 24-hour and a 30-day Safety Assessment were completed, they did not accurately reflect the case record. A 24-hour Fatality Report was not approved until 2 weeks after the due date. Some progress notes were not entered contemporaneously during the investigation.

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

Issue:
A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.

Summary:
Although a 24-hour Safety Assessment was completed timely, a 24-hour Fatality Report was not completed in Connections within 24 hours of receipt of the report. The 24-hour Fatality Report was approved 2 weeks after the due date.

Legal Reference:
CPS Program Manual, Chapter 6, K-1

Action:
OCDSS must complete a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment.

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
Although most progress notes were entered timely, some progress notes were not entered contemporaneously during the investigation, and were documented up to 3 months after the event date.

Legal Reference:
18 NYCRR 428.5

Action:
Progress notes must be entered as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:
Timely/Adequate 30-Day Safety Assessment

Summary:
Although there was a Safety Plan in place that was referenced in the Safety Assessment, the appropriate Safety Decision was not selected.

Legal Reference:
CPS Program Manual, Chapter 6, K-2

Action:
The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances with regard to safety.

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
The 24-hour Safety Assessment and 30-day Safety Assessment did not reflect information in the case record. The Safety Decision did not include the Safety Plan or controlling interventions that were made with the family, which included not allowing the father to be unsupervised with the SS.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:
Safety Assessments must include any Safety Plan developed or other controlling interventions made during the course of the investigation. The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/21/2018	Deceased Child, Male, 6 Days	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Pending	Yes
	Sibling, Female, 6 Days	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Pending	

Report Summary:
An SCR report received on 5/21/18 alleged the mother gave birth to twins. The children's meconium tests came back positive for marijuana. The role of the father was unknown.

Report Determination: Undetermined

OCFS Review Results:
OCDSS made appropriate collateral contacts and made extensive casework contact. Although OCDSS later identified the error, the 7-day Safety Assessment was inaccurately completed. Some progress notes were not entered contemporaneously to their event dates.

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

Issue:
Review of CPS History
Summary:
Although the caseworker documented asking the family about CPS history, OCDSS did not document reviewing any SCR or CPS history regarding the family until 3 days after the due date.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, OCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, OCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Although most progress notes were entered timely, some were not entered contemporaneously during the investigation, and were documented up to 3 months after the event date.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
Progress notes must be entered as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
The 7-day Safety Assessment did not reflect information within the case record. Documentation within the case record stated the children were born with a positive toxicology for marijuana and this was known prior to the completion of the Safety Assessment, but was not selected as a safety factor. The 7-day Safety Assessment was completed timely, but was not approved 1 day after the due date.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:
OCDSS will complete all assessments and accurately reflect the safety factors that are present, along with any Safety Plan that has been devised. Safety Assessments will be completed and approved within the required timeframes.

[redacted]

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

05/01/02 - 08/12/02 The allegation of EdN was substantiated against MGM and MGF regarding their children.

03/28/06- 06/12/06 The allegation of EdN was substantiated against MGM and MGF regarding their children.

Known CPS History Outside of NYS

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

Legal History Within Three Years Prior to the Fatality

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

Additional Local District Comments

32% of the 161 notes were entered with an event date between June 16-June 18, 2018. 14 of the notes that were entered after 30 days occurred with an event date between June 16-June 20, 2018. June 16, 2018 is when Twin B passed away and the events that occurred during those dates were extremely intense. The complexity of the situation during those dates, including having three open reports at once for the twins (two being fatality reports) should be taken into consideration in the assessment of timely documentation. Otsego DSS independently identified and documented that the 7-day safety assessment was inaccurate. This was noted in a June 7, 2018 supervisory note. Regarding the 30-day safety assessment, it is important to emphasize that safety and risk determination of the case was correct because the safety assessments and notes both note that enough information had been gathered to determine the need and implementation of a safety plan. Although the safety decision two was chosen and not safety decision three, the safety assessment and notes clearly state the safety concerns and the controlling intervention/safety plan. It is important to note that Otsego County DSS has petitions pending o be filed in Family Court against the mother and father. They have been drafted and are being reviewed by the legal department.

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