Child Fatality Report

Report Identification Number: SV-18-032

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

Issue Date: Nov 07, 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: 3 month(s)
Jurisdiction: Orange
Gender: Male
Date of Death: 05/21/2018
Initial Date OCFS Notified: 05/21/2018

Presenting Information

An SCR report received on 05/21/18 alleged that the SC died on 05/21/18 at 11:00AM. The mother had previously been co-sleeping with the SC. There was no explanation as to how the SC died and therefore, the child's death was suspicious in nature. The SC was born on 02/15/18, with a positive toxicology of cocaine; the mother had a history of drug abuse. The parents were named subjects of the report as they were home at the time of the SC's death. The role of the SS was unknown.

Executive Summary

This fatality report concerns the death of the 3-month-old male SC. On 05/21/18, Orange County Department of Social Services (OCDSS) received an SCR report regarding the fatality. The report alleged that the SM had been co-sleeping with the SC and woke to find him unresponsive and not breathing. The SF was made a subject of the report as he was home at the time of the child's unexplained death. The report additionally included concerns of the SC's positive toxicology for an illicit drug at the time of his birth and the concern of the SM's history of drug abuse. The fatality report was subsequent to an open investigation regarding concerns of the SC's positive toxicology, inadequate housing and food for the children, and loose medication accessible to the SS. The family had an open Preventive Services case at the time of the SC's death.

EMS responded to the scene and attempted to resuscitate the SC and transported him to the hospital where he was pronounced deceased. An autopsy was completed, listing the cause and manner of death as undetermined.

OCDSS worked in conjunction with LE for the duration of the investigation. At the time that this report was written, SC's death remained under criminal investigation, but LE did not believe the SC's death would result in criminal charges.

It was found that the SM was co-sleeping with the SC at the time of his death while the SF and SS were in another room. OCDSS assessed the SS to be safe with his MGM immediately after being notified of the fatality.

OCDSS contacted relevant collaterals during the investigation, including medical professionals and the MGM; however, OCDSS did not interview MGM or speak with her about the allegations. OCDSS created a safety plan with the family for the SS to be in the care of the MGM throughout the investigation to safeguard him from possible risk of harm while the investigation was carried out.

From the time of the SC's birth to the time this report was written, OCDSS offered drug abuse evaluations and mental health counseling to the SM. On multiple occasions she declined services, referrals and recommendations. Due to the SM continuously declining assistance for her suspected continued substance abuse, and failing to understand the seriousness of her actions, OCDSS filed a neglect petition against her on behalf of the surviving sibling in Orange County Family Court.

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:
The casework activity was commensurate with case circumstances.

Was the decision to close the case appropriate? Yes

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

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

Explain:
The decision to close the investigation was appropriate. Preventive Services for the family remained open, and OCDSS filed a neglect petition in Family Court against the SM regarding her refusal to obtain mental health and drug abuse evaluations and resulting impairment of her ability to care for the surviving sibling.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	OCDSS selected "caretaker attends to the needs of all CHN and prioritizes the CHN's needs above his/her own needs or desires" in the RAP; however, OCDSS indicated an allegation against SM for not putting the CHN's needs above her own.
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.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	There were missed opportunities to gather collateral information. The grandmother was the caregiver and safety plan for the SS and there was not documentation she was interviewed regarding any possible concerns for the SS' safety and wellbeing.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)

Action:	A full child protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, and other individuals residing within the subject household. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/21/2018 **Time of Death:** 11:22 AM

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

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used 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
At time of incident supervisor was: Unknown if they were 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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	33 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

Within 24 hours of receiving the report, OCDSS coordinated their investigative efforts with LE, notified the DA and completed a CPS history check. OCDSS contacted the source of the report to gather more information.

The mother was interviewed by LE and the 2yo SS was observed with his maternal grandmother. In her care, the SS was assessed to be safe. OCDSS created a safety plan for the SS to remain with the grandmother during the investigation.

The father denied knowing specifics of the SC's death as he was sleeping in another room with the SS. He woke around 4:45AM on 05/21/18 to feed the SS, at that time, he heard the SC crying and the mother talking to the SC. Despite having a bassinet, the SC regularly slept in a bouncy seat due to a medical condition affecting his breathing. SC was hospitalized twice due to his condition and was reported to hold his breath, bear down and turn purple. There were no significant medical findings. SC was prescribed medication to ease his condition, which his parents were administering to him as directed. The parents used an aspiration ball when the SC vomited through his mouth and nose.

The father reported last seeing the SC around 12:00AM when he buckled the SC into the bouncy seat. The SC was breathing normally. The parents never placed the SC flat on his back, keeping him on an incline, despite being informed of safe sleeping recommendations.

The father said the mother alerted him of the SC being unresponsive and not breathing. The time was unknown. He called 911 and was given instruction on CPR. The mother said the SC was light in color. LE responded to the home quickly and the SC was transported to the hospital via ambulance. At 11:22AM, the SC was pronounced deceased.

OCDSS and LE observed a reenactment of the incident. The mother said she was sleeping with SC on the mattress, and he was on top of some blankets. The mother was bed sharing with the SC because his bouncy seat was wet. She reported placing the SC on his side, with his upper-body propped on pillows and found him on his back and bubbles coming out of his mouth.

The criminal investigation continued at the time this report was written. Information was obtained about drug paraphernalia inside of the SC's home. LE executed a search warrant and located multiple pieces of drug paraphernalia, including in the room where the SS slept.

OCDSS made collateral contacts including doctors and service providers. OCDSS used information obtained to unsubstantiate the parents for the fatality allegations, the mother for her drug abuse and the father for IG regarding the SC, due to lack of credible evidence. The report was indicated against the mother for IG regarding the SC, due to her continuous refusal to engage in mental health and drug addiction evaluations. The case record did not show how the mother's actions or inactions impacted the SC or the SS.

After the mother's continued refusal of drug and mental health evaluations, OCDSS filed a neglect petition in Family Court on August 9, 2018.

OCDSS offered bereavement counseling; the services were declined. OCDSS offered burial assistance, but it was unknown if it was used. SF continued his drug abuse and mental health treatment.

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: 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
Comments: The fatality was reviewed by an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046894 - Deceased Child, Male, 3 Mons	046895 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
046894 - Deceased Child, Male, 3 Mons	046896 - Father, Male, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
046894 - Deceased Child, Male, 3 Mons	046895 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
046894 - Deceased Child, Male, 3 Mons	046895 - Mother, Female, 29 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
046894 - Deceased Child, Male, 3 Mons	046896 - Father, Male, 33 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?	☒	☐	☐	☐

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 asked for tips in disciplining the 2yo sibling, there was not clear documentation of parenting services offered to the family.

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:
OCDSS created a safety plan with the parents and maternal grandmother regarding the safety of the SS. It was agreed upon that the mother will not be left alone with the SS, and the grandmother will be supervising the SS at all times.

Legal Activity Related to the Fatality

Was there legal activity as a result of 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:**
08/09/2018	There was not a fact finding	There was not a disposition
Respondent:	046895 Mother Female 29 Year(s)	
Comments:	A Neglect Petition was filed in Orange County Family Court against the mother on August 9, 2018. The petition alleged the SC was born with a positive toxicology for an illegal drug. It was alleged that the mother was abusing the illegal drug and was not enrolled in a substance abuse treatment program. The mother appeared to be "off-balance" at a pediatric appointment. Additionally, the petition alleged the mother admitted to abusing an illegal drug and a search warrant of her home was carried out, resulting in locating drug paraphernalia.	

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:
On multiple occasions since the SC's birth, the SM has been offered mental health counseling and drug abuse evaluations, but has refused to participate. However, a referral was not made for the family to participate in parenting skill classes, despite asking for recommendations on disciplining the SS.

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? No
Explain:
Although, the SS is too young to speak about the incident, the record does not show that he was evaluated regarding any possible service needs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents and the maternal grandmother were offered services including substance abuse counseling, mental health counseling and services provided through a community based program focusing on assisting those who have experienced trauma, and intensive case management. The mother continuously refused drug abuse and mental health counseling. The father received MH counseling prior to the fatality and continued to receive services privately. The grandmother planned to accept grief counseling.

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?	Yes

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)
05/10/2018	Deceased Child, Male, 3 Months	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 3 Months	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Months	Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 3 Months	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report received on 05/10/18 alleged that SM and SF were residing with SC and SS in a home that was a fire hazard. There were clothes piled up so high on the floors that items had to be kicked out of the way to make a pathway. There were large items blocking stairs and doors that would make egress during a fire difficult. There was dried food all over SS' high chair and it was covered in filth. The SC was sleeping in a bassinet in the hallway, surrounded by clothes. There were loose pills all over the floor in the bedroom, accessible to the children. There was no food in the home for the children.

Report Determination: Unfounded | **Date of Determination:** 08/17/2018

Basis for Determination:
The investigation was unfounded, stating that the investigation did not reveal credible evidence to substantiate the allegations and a collateral contact did not have concerns for the family. The home was observed to have no objects blocking exits and ample food was available. There were no medication observed to be accessible to the children and the home was clean.

OCFS Review Results:
An interview with the maternal grandmother was not documented. Although a OCDSS attempted a home visit, and consulted with the preventive worker, the safety of the children was not documented to be assessed until 5 days after the receipt of the report. The Risk Assessment Profile did not reflect information within the case record. The investigation determination was not appropriate considering information documented in the case record, and a Neglect Petition was filed in Family Court due to concerns for the safety of the SS, the SM's drug abuse and refusal to obtain MH counseling. A 7-day Safety Assessment did not reflect case circumstances.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7 day Safety Assessment did not accurately reflect the case circumstances. The SC was born with a positive toxicology for illicit drugs, yet it was not selected on the Safety Assessment.

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

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

Issue:
Appropriateness of allegation determination
Summary:
The allegation of IG against SM was unsubstantiated, stating there was no credible evidence; however, a safety plan was created and OCDSS filed a Neglect Petition in Family Court regarding SM's refusal to obtain MH and drug addiction counseling. A concurrent investigation substantiated the allegation against the mother due to serious concerns regarding her inability to care for the sibling.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
OCDSS will refer to the CPS Program Manual and/or consult with the Spring Valley Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP documents the SM is willing to address any areas of concern, and that she tends to the needs of her children above her own desires. A Neglect Petition was pending against SM for refusing mental health and drug abuse evaluations, and a safety plan was required because the mother was unable to adequately care for the child.
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.

Issue:
Timely/Adequate 24 Hour Assessment
Summary:
OCDSS did not document assessing the safety of the SS or SC within 24 hours after the receipt of the report. Although the source of the report was contact and a collateral contact was made with a service provider for the family, there is not documentation that speaks to the safety of the children. The first assessment of the children was not completed until 5 days after the receipt of the report.
Legal Reference:
SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:
OCDSS will adequately assess safety of children respective to case circumstances within 24 hours of each SCR report. OCDSS must conduct a face-to-face contact or a telephone contact with the subject and/or other persons named in the report or other persons in a position to provide information about whether the child may be in immediate danger of serious harm.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:

During the investigation, there were missed opportunities to gather collateral information. The grandmother was the caregiver and safety plan for the surviving sibling and there was not documentation that she was interviewed regarding any possible concerns for the surviving sibling's safety and wellbeing.

Legal Reference:

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

Action:

A full child protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, and other individuals residing within the subject household. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/16/2018	Deceased Child, Male, 1 Days	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:

An SCR report alleged the subject mother gave birth on 2/15/18 and the mother tested positive for cocaine. At the time the report was made, the child's toxicology was pending. It was unknown if SM had ever used any drugs while caring for her 21-month-old son. The father and the 21-month-old SS had unknown roles.

Report Determination: Unfounded | **Date of Determination:** 04/09/2018

Basis for Determination:

The allegation of PD/AM against the SM for the SC was unsubstantiated. Although SM tested positive for cocaine at the SC's time of birth, there was no known medical effect on the SC. The SC was observed for 72 hours at the hospital and did not show signs of symptoms of drug withdrawal.

OCFS Review Results:

OCDSS did not provide safe sleeping literature to the family nor document observing the sleeping area of the SS. OCDSS obtained information regarding the long history of both the parents abusing drugs and having mental health concerns. OCDSS appropriately referred the family to Improving Families Program on 2/16/18 for intensive monitoring of the home. The report was appropriately unfounded and opened as a Family Services Stage.

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

Issue:

Failure to provide safe sleep education/information

Summary:

Although OCDSS did not document providing safe sleep literature to the family or going over safe sleeping recommendations with the father, they were in the home during any point in the investigation, it was documented that the worker observed the child under a heavy blanket and advised the mother to remove the blanket.

Legal Reference:

13-OCFS-ADM-02

Action:

OCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the child/ren in their care. OCDSS will assess the child/ren's sleep environment, irrespective of the age of the child/ren and must document details in progress notes.

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

There was no known CPS history more than 3 years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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: 02/16/2018

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: 02/16/2018

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

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐

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 FASP was due on 05/17/18 and was not approved until 6/24/18.				
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:
The family was involved with Youth Advocate Programs Orange during the open Preventive case.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Failure to Offer Services
Summary:	OCDSS did not offer parenting services to the family during the open Preventive Case despite the SM stating she was overwhelmed and would like suggestions regarding managing the SS.
Legal Reference:	SSL 424(10); NYCRR 428.6
Action:	When service needs are identified, OCDSS will make the appropriate referrals and provide services that may benefit the family.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Multiple progress notes were not entered contemporaneously during the investigation, and were documented approximately 13 weeks after the event date.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	All progress notes will be entered as contemporaneously as possible to their event dates.
Issue:	Timeliness of completion of FASP
Summary:	The initial and comprehensive FASPs were not completed on time. The initial FASP was 2 days late. The information in the FASP does not accurately reflect the information within the case record.
Legal Reference:	18 NYCRR428.3(f)
Action:	OCDSS will complete timely and accurate FASPs.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The safety assessments do not accurately reflect documentation in the case record. A safety plan was created for the SS and was not reflected in the safety assessments. The SC was medically fragile yet the safety factor was not chosen.
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.

Preventive Services History

A Preventive case was opened for the family on 03/05/18. The Preventive case was opened because the mother and the SC tested positive for cocaine at the time of the SC's birth. The case was opened voluntarily and included a community based program. There were concerns of the both parents had a history of substance abuse and mental health concerns. The mother was not following through with recommendations to seek mental health services or a drug abuse evaluation. The father was compliant with mental health and drug counseling, which he was receiving from an outside agency before concerns were brought to OCDSS' attention. The case remained open at the time this report was written.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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