Office of Children and Family Services

# Child Fatality Report

## Report Identification Number: SV-19-019

## 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
**Age:** 3 month(s)
**Jurisdiction:** Sullivan
**Gender:** Female
**Date of Death:** 04/24/2019
**Initial Date OCFS Notified:** 04/24/2019

### Presenting Information

An SCR report alleged on 4/24/19, the parents were co-sleeping with the child. When the parents awoke, they found the child laying on her side, unresponsive and between the wall and one of the parents. One of the parents called 911 and EMS responded to the home. There was no explanation for the child's death as she was an otherwise healthy child with no known medical issues or ailments that may have contributed to her passing. The role of the two surviving siblings and their father were unknown.

### Executive Summary

This fatality report concerns the death of the 4-month-old female subject child who died on 4/24/19. An SCR report was made regarding the child's death, which alleged the child had no preexisting medical conditions that would explain her death. The child resided with her parents and paternal grandfather. The family had an open Family Services Intake at the time of death and an open CPS investigation. There were two surviving siblings, aged three and four years, who resided with their father. The siblings were assessed to be safe in the care of their father.

Sullivan County Department of Social Services (SCDSS) coordinated investigative efforts with law enforcement immediately upon receipt of the SCR report. Law enforcement's criminal investigation remained open at the time this report was written; however, the District Attorney declined to file any charges regarding the death. An autopsy was performed and the forensic pathologist listed the manner of death as undetermined circumstances and the cause of death was "sudden unexpected death of 4-months-infant in Boppy pillow, co-sleeping with adults on a bed" (child was one day shy of being 4 months old). It remained unknown if there were additional pillows or blankets on the bed.

The parents explained they were sharing a bed with the child when the father awoke to find the child unresponsive and not breathing. The parents "freaked out" and did not know what to do. The paternal grandfather arrived home, 911 was called, and CPR was performed. EMS responded and resuscitation efforts were discontinued as rigor mortis had set in.

The caseworker made home visits to the child's home, as well as the home of the siblings, and the safety of the siblings was assessed throughout the investigation. A multitude of services including bereavement and mental health counseling, funeral assistance, and drug and alcohol evaluations were offered to the family. Some services were utilized.

SCDSS gathered information from the pediatrician, law enforcement, EMS, and the school of the children. Drug treatment facilities were contacted regarding the parents' history of drug and alcohol abuse. The record did not reflect if the parents were impaired at the time of the child's death.

SCDSS conducted a thorough investigation and contacted necessary collaterals. SCDSS completed the required reports and Safety Assessments timely; however, the safety factor regarding parent drug abuse was selected. The record did not contain information that the mother was abusing drugs during the investigation. The Safety Assessments did not include the safety plan that was created by SCDSS for the mother to not be left unsupervised around the siblings. The Risk Assessment Profile included the subject child, despite her death.

SCDSS substantiated the allegations of Inadequate Guardianship and DOA/Fatality against both parents as they placed the child in an unsafe sleep environment with aggravating factors; the parents were alleged to have been medicated/under the influence of several substances, and the size of the sleeping surface in relation to the occupants created an unsafe

condition. It was documented in the Investigation Conclusion narrative that the parents were medicated/under the influence of several substances on the morning of 4/24/19 while co-sleeping with the child; however, the record did not reflect the parents were impaired while caring for the child. Additionally, the Investigation Conclusion narrative noted the child died of "S.I.D.S."; however, the child was determined to have died of Sudden Unexpected Death in Infancy.

**PIP Requirement**

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

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

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

**Determination:**

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

**Explain:**

There were inconsistencies between the progress notes and the basis for determination documented in the Investigation Conclusion narrative. The basis for substantiating IG and DOA/Fatality against the parents included the parents' drug impairment; however, the allegation of PD/AM was not added, and the record did not state the parents were impaired at the time of the fatal incident.

**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 case was thoroughly investigated.

## Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Failure to provide notice of report |
| **Summary:** | Although written notice of the report was provided timely to the parents and to the father of the siblings, written notice was not provided to the grandfather. The grandfather resided in the household and was added to the investigation. |
| **Legal Reference:** | 18 NYCRR 432.2(b)(3)(ii)(f) |
| **Action:** | SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well. |
| | |
| **Issue:** | Adequacy of Documentation of Safety Assessments |
| **Summary:** | Although the Safety Assessments were completed timely, they were inaccurate. The safety factor regarding drug abuse was selected and the record did not show the mother was impaired. The Safety Assessment did not include the safety plan. |
| **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. |
| | |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 04/24/2019 **Time of Death:** Unknown

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

**County where fatality incident occurred:** Sullivan
**Was 911 or local emergency number called?** Yes
**Time of Call:** 12:44 PM
**Did EMS respond to the scene?** Yes
**At time of incident leading to death, had child used alcohol or drugs?** N/A
**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 ☐ Absent
☐ Alcohol Impaired ☒ Asleep
☐ Distracted ☐ Impaired by illness
☐ Impaired by disability ☐ Other:

**Total number of deaths at incident event:**

**Children ages 0-18:** 1

**Adults:** 0

**Household Composition at time of Fatality**

| Household | Relationship | Role | Gender | Age |
|---|---|---|---|---|
| Deceased Child's Household | Deceased Child | Alleged Victim | Female | 3 Month(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 32 Year(s) |
| Deceased Child's Household | Grandparent | No Role | Male | 66 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 29 Year(s) |
| Other Household 1 | Other Adult - BF of SS | No Role | Male | 42 Year(s) |
| Other Household 1 | Sibling | No Role | Male | 3 Year(s) |
| Other Household 1 | Sibling | No Role | Male | 4 Year(s) |

**LDSS Response**

SCDSS coordinated investigative efforts with LE upon receipt of the SCR report received on 4/24/19. SCDSS contacted the source of the report, documented a CPS history check and made a home visit within the first 24 hours of being notified of the death. The DA's office was notified of the death through the multi-disciplinary team (MDT). A subsequent report was received the following day regarding the death.

On 4/24/19, a home visit was made to the home of the SS. At that time, few details were known regarding the death and the caseworker made a safety plan with the paternal uncle to not allow the SM around the SS until the investigation was completed. The SS were observed to be safe in the care of their uncle, who was watching them while their father worked.

On 4/25/19, SCDSS interviewed the SF at home. The SF said the SC was resting when she cried around 10:00 AM. The SM fed the SC and propped her on a "Boppy pillow" on the bed, next to a wall. She laid down next to the SC and he was on the other side of the SM. Around 12:30 PM, the SF observed the SC unresponsive. He "freaked out" and did not know what to do. The grandfather came home and the SF called 911 at approximately 12:44 PM. He reported the SC slept "normal" and had a stuffy nose and minor cough.

During the home visit, the SM arrived with the father of the SS. The caseworker spoke with him, and they agreed upon a precautionary safety plan to not allow the SM to be unsupervised around the SS. He did not have concerns and he did not have information regarding the death.

The SM was interviewed and was advised she was not to have contact with the SS without their father present. She said she and the SF slept on their bed with the SC on 4/24/19. She placed the SC on a "Boppy pillow" around 10:00 AM, and around 11:00 AM, the SF noticed the SC was unresponsive and called the police. She reported the SC was acting normally the night prior to the death. The SM was in a drug treatment program and took her prescribed medication as directed.

The parents said the family was working with a public health nurse. The MDT gathered information from the nurse and the pediatrician, who said the SC experienced significant withdrawal after her birth due to the SM's drug use during pregnancy. The SM's medical provider was unaware she was pregnant, and continued to prescribe medications that were contraindicated in pregnancy.

On 5/2/19, attempts were made to interview the SS; however, they were unable to provide any information and were not in the home during the fatal incident.

The grandfather was interviewed on 5/2/19. He reported leaving the home around 7:30 AM, returning around 9:00 AM. He spoke to the SF through the door, and no concerns were noted. He left the home again, and when he came back, the SF was holding the SC and was crying. The SF said the SC was suffocated. The SM was standing next to him, in shock. He told the SF to call the police. The grandfather said the SC was a little fussy and congested, but had attributed it to the SC teething. He reported the SC was born prematurely with a low birth weight, but the public health nurse was monitoring the SC and was satisfied with her growth and development.

SCDSS gathered more collateral information from first responders, including law enforcement and EMS. When EMS arrived, rigor mortis had set in and life saving measures were not performed. EMS reported "the baby was dead for a long period of time and there was nothing we could do."

Prior to determining the investigation, SCDSS offered the family several services, including burial assistance, mental health counseling, drug/alcohol evaluations and bereavement services. The family declined any services for the SS, and accepted bereavement counseling and engaged in drug/alcohol evaluations. The funeral home assisted with burial costs. As there were no surviving children in the home, the Family Services Intake was closed on 5/14/19.

## Official Manner and Cause of Death

**Official Manner:** Undetermined
**Primary Cause of Death:** From an injury - external cause
**Person Declaring Official Manner and Cause of Death:** Forensic Pathologist

## Multidisciplinary Investigation/Review

**Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?** Yes
**Comments:** The death was referred to the Multi-disciplinary team during the course of the investigation.

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

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 051027 - Deceased Child, Female, 3 Mons | 051028 - Mother, Female, 29 Year(s) | Inadequate Guardianship | Substantiated |
| 051027 - Deceased Child, Female, 3 Mons | 051029 - Father, Male, 32 Year(s) | DOA / Fatality | Substantiated |
| 051027 - Deceased Child, Female, 3 Mons | 051028 - Mother, Female, 29 Year(s) | DOA / Fatality | Substantiated |
| 051027 - Deceased Child, Female, 3 Mons | 051029 - Father, Male, 32 Year(s) | Inadequate Guardianship | Substantiated |

## CPS Fatality Casework/Investigative Activities

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **All children observed?** | ☒ | ☐ | ☐ | ☐ |
| **When appropriate, children were interviewed?** | ☒ | ☐ | ☐ | ☐ |
| **Alleged subject(s) interviewed face-to-face?** | ☒ | ☐ | ☐ | ☐ |
| **All 'other persons named' interviewed face-to-face?** | ☒ | ☐ | ☐ | ☐ |
| **Contact with source?** | ☒ | ☐ | ☐ | ☐ |
| **All appropriate Collaterals contacted?** | ☐ | ☒ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☒ |
| **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?** | ☐ | ☒ | ☐ | ☐ |

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **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 parents accepted bereavement and mental health counseling. The father of the surviving siblings declined services for the children. | | | | |

## 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.

## 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?** No
**Explain:**
Due to their ages, no service needs were identified for the siblings.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
Grief counseling, bereavement services, mental health assessments and drug/alcohol evaluations were offered to the parents.

## 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?** 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) |
|---|---|---|---|---|---|
| 02/27/2019 | Deceased Child, Female, 2 Months | Father, Male, 32 Years | Inadequate Guardianship | Substantiated | No |
| | Deceased Child, Female, 2 Months | Father, Male, 32 Years | Lack of Medical Care | Substantiated | |
| | Deceased Child, Female, 2 Months | Mother, Female, 29 Years | Inadequate Guardianship | Substantiated | |
| | Deceased Child, Female, 2 Months | Mother, Female, 29 Years | Lack of Medical Care | Substantiated | |
| | Deceased Child, Female, 2 Months | Mother, Female, 29 Years | Parents Drug / Alcohol Misuse | Unsubstantiated | |
| | Deceased Child, Female, 2 Months | Father, Male, 32 Years | Inadequate Food / Clothing / Shelter | Unsubstantiated | |
| | Deceased Child, Female, 2 Months | Mother, Female, 29 Years | Inadequate Food / Clothing / Shelter | Unsubstantiated | |

**Report Summary:**
An SCR report alleged the SM gave birth on 12/25/18. The SM and SC tested positive for cocaine and non-prescribed barbiturate and Subutex. The SM was under the influence of unknown substances while acting as the primary caregiver for the SC to the point the SM was unable to provide a minimal degree of care. The SC had withdrawal symptoms and it was unknown if the SM continued to expose the SC to drugs. The parents failed to provide the SC with medical appointments with a specialist and her pediatrician despite the severe need for ongoing medical oversight. The SC did not gain weight, had reflux and did not have ample clothing or formula. The home was cold and the SC's feet were blue.

**Report Determination:** Indicated | **Date of Determination:** 06/11/2019

**Basis for Determination:**
The parents were substantiated regarding IG and LMC as the investigation revealed the child missed several medical appointments and suffered from withdrawal symptoms. The allegation of IF/C/S was unsubstantiated as the home was a reasonable temperature and the family had an adequate supply of formula for the child. The allegation of PD/AM was unsubstantiated against the mother. The investigation revealed the mother always appeared sober during unannounced home visits and appeared capable of caring for the infant.

**OCFS Review Results:**
SCDSS initiated the investigation timely by contacting the source of the report and checking CPS history. The interviews with family and collaterals were thorough. The family was provided with written notice of the SCR report timely. Safety Assessments were completed accurately. PD/AM against the mother was not substantiated despite the child's positive toxicology at birth and withdrawal symptoms. Safe sleep guidelines were provided to the family and the family was offered Preventive Services, which were accepted.

**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) |
|---|---|---|---|---|---|
| 12/25/2018 | Deceased Child, Female, 1 Days | Mother, Female, 29 Years | Inadequate Guardianship | Unsubstantiated | Yes |
| | Deceased Child, Female, 1 Days | Mother, Female, 29 Years | Parents Drug / Alcohol Misuse | Unsubstantiated | |

**Report Summary:**
An SCR report made on 12/25/18, alleged the mother gave birth to a baby girl the same day. At the time of delivery, the mother tested positive for marijuana, Suboxone and benzodiazepines.

**Report Determination:** Unfounded | **Date of Determination:** 02/19/2019

**Basis for Determination:**
SCDSS unsubstantiated the allegations against the mother regarding the subject child. The child experienced withdrawal symptoms and was admitted to the hospital for treatment before being released to the care of her mother. SCDSS noted the mother was prescribed the medication the child withdrew from. SCDSS did not substantiate concerns of Inadequate Guardianship due to domestic violence as there were no signs that the child was injured, and the parents denied any physical domestic violence.

**OCFS Review Results:**
SCDSS initiated their investigation, documented a CPS history check and assessed the safety of the child timely. Written notice of the report was provided to the parents of the child; however, was not provided to the father of the siblings. The Safety Assessments did not reflect information in the case record. There were missed opportunities for collateral contacts. SCDSS offered the family Preventive Services and opened a Family Services Stage.

**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 include the child was born with a positive toxicology for drugs. The Safety Assessment was approved two days after the due date.
**Legal Reference:**
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
**Action:**
SCDSS will clearly document assessment of safety and risk of all children in the household within the required timeframe of 7 days. SCDSS will complete all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.

**Issue:**
Adequacy of Documentation of Safety Assessments
**Summary:**
The Safety Assessment completed at the time of case closure did not identify safety factors which were documented in the case record. Her positive toxicology at the time of birth was not reflected in the Safety Assessments.
**Legal Reference:**
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
**Action:**
SCDSS will complete all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.

**Issue:**
Contact/Information From Reporting/Collateral Source
**Summary:**
Although the siblings were seen, there were missed opportunities to collect collateral information as the CW did not attempt to speak with the children regarding their safety and possible risk factors. Furthermore, the record did not show attempts to contact a friend, who was present during one of the alleged domestic disputes between the parents.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(b)
**Action:**

SCDSS will contact or make diligent efforts to contact relevant collateral sources who may have information relevant to the investigation.

**Issue:**
Failure to provide notice of report

**Summary:**
Although the parents of the child were provided with written notice of the report timely, the father of the siblings was not documented to have been provided with written notice.

**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)

**Action:**
SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 07/07/2017 | Sibling, Male, 2 Years | Mother, Female, 28 Years | Inadequate Guardianship | Unsubstantiated | Yes |
| | Sibling, Male, 1 Years | Mother, Female, 28 Years | Inadequate Guardianship | Unsubstantiated | |
| | Sibling, Male, 2 Years | Mother, Female, 28 Years | Lacerations / Bruises / Welts | Unsubstantiated | |

**Report Summary:**
An SCR report alleged on 7/7/17, the mother acted in an out of control manner in the presence of the siblings. The mother smashed a window to the home after the father locked her out during an argument. As a result, the then 2-year-old sibling sustained a cut to his left foot from the shattered glass which required medical attention. The role of the father was unknown.

**Report Determination:** Unfounded | **Date of Determination:** 10/02/2017

**Basis for Determination:**
SCDSS unsubstantiated the allegations noting that the mother was acting in an out of control manner around the children; however, due to their ages, there was no evidence that the children were negatively impacted by her behavior.

**OCFS Review Results:**
SCDSS initiated the report and assessed the children timely. The parents were interviewed and written notice of the report was provided. The Safety Assessments did not reflect information within the case record and the 7-day Safety Assessment was not approved timely. The Risk Assessment Profile did not include the domestic violence between the mother and the father of the siblings. The investigation was unsubstantiated despite credible evidence documented within the case record.

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

**Issue:**
Timely/Adequate Seven Day Assessment

**Summary:**
Although the 7-day Safety Assessment was completed timely, it was not approved until 17 days after the due date. The Safety Assessment did not reflect information in the case record that the mother was out of control when she broke a window, causing the glass to fall on the 2-year-old sibling. The mother also physically assaulted the father in the presence of the children.

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

**Action:**

SCDSS will clearly document assessment of safety and risk of all children in the household within the required timeframe of 7 days.

**Issue:**
Adequacy of Risk Assessment Profile (RAP)
**Summary:**
The RAP was completed inaccurately as it did not include the BF of the SS and SM's history of physical domestic violence that required law enforcement intervention.
**Legal Reference:**
18 NYCRR 432.2(d)
**Action:**
SCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

**Issue:**
Appropriateness of allegation determination
**Summary:**
The allegations were unsubstantiated despite credible evidence documented within the case record. The case recorded included police involvement due to DV, the BF of SS said the mother punched him, and the mother said he pushed her in the presence of the children. The sibling also sustained a cut to his foot as a result of the mother breaking glass.
**Legal Reference:**
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
**Action:**
SCDSS 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).

[redacted]

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

8/23/13- 12/6/13 SM and BF of SS Sub for IG, PD/AM regarding the SS.

8/4/14- 12/24/14 SM, BF of SS Sub for IG and LMC regarding 4yo SS. Unsub for PD/AM regarding 4yo SS against SM and BF of SS. SM, BF of SS, PU, and OA UnSub for IG of OC. UnSub for LMC against PU and OA regarding 4yo SS.

## Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

## Preventive Services History

An FSI was opened on 2/4/19 after a referral was made by a CPS worker. There were concerns the SC was born with a positive toxicology and experienced withdrawal symptoms of tremors, irritability and an elevated heart rate. The SM worked with a Public Health Nurse who had concerns of the SM's inability to care for the SC and she missed pediatrician appointments. There were concerns of verbal DV between the parents. The SF signed the required documentation to open Preventive Services; however, the FSI was not progressed into an FSS. The surviving siblings and their father were added to the case; however, the record did not reflect they were ever assessed or engaged in the Preventive Services case. The PGF was added to and engaged in the case as he resided in the home with the parents and SC. The record did not reflect

the SC was observed by SCDSS or the SM was engaged in Services until 3/19/19 and the family continued to miss appointments with WIC and medical providers. The CW discussed safe-sleep guidelines. The SM was provided with a DV referral. It remained unknown if she utilized the service. The record did not reflect the SC was seen in April. Progress notes were not entered contemporaneously and were entered up to two months after their event dates. The case was closed on 5/14/19 and stated there was no longer a child in the home.

## 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