Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-20-047

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

Issue Date: May 10, 2021

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Ulster
Gender: Male
Date of Death: 11/10/2020
Initial Date OCFS Notified: 11/10/2020

Presenting Information

Ulster County Department of Social Services (UCDSS) received a report from the SCR on 11/10/20 regarding the death of the 1-month-old male subject child. The mother gave the subject child a bottle around 8:45AM and she and the child fell asleep in bed together. The mother woke and was on top of the subject child. The child was not breathing. The mother called 911 and first responders arrived and began CPR. The child was transported to the hospital where he was pronounced deceased at 12:09PM. A subsequent SCR report was received on 11/17/20 which alleged the mother was under the influence of heroin at the time of the infant's death.

Executive Summary

On 11/10/20, UCDSS received an SCR report regarding the 1-month-old infant's death that occurred on the same date. At the time of the infant's death, he resided with his mother and father. A 5-year-old sibling resided with the maternal grandmother and had limited, supervised contact with the mother.

UCDSS conducted a joint investigation with law enforcement and learned that on 11/10/20 around 8:45 AM, the mother gave the infant a bottle and placed him to sleep in the bed with her. She woke shortly after 11AM and found she was on top of the infant and he was blue and unresponsive. The mother called 911 at 11:18AM. Emergency services responded and began resuscitation efforts before transporting the infant to the hospital. The infant was pronounced deceased at 12:09PM on 11/10/20.

UCDSS interviewed the parents immediately upon receipt of the fatality report. Following initial interviews, the parents became uncooperative and refused to meet with UCDSS. The parents refused to allow UCDSS into the home, stating it was a mess from the police execution of a search warrant. UCDSS interviewed the maternal grandmother who had custody through family court of the 5-year-old sibling. The sibling was safe in the maternal grandmother's care and had limited contact with the mother, all of which was supervised. The sibling had been in the care of the grandmother since May, 2019.

UCDSS closed the investigation on 1/18/21. At that time, the autopsy results were pending, and the law enforcement investigation remained open pending the final autopsy report. The preliminary autopsy report was received, which showed a torn frenulum. The ME reported this could have been caused by smothering, aggressive feeding, or attempts to intubate during lifesaving efforts. The infant's toxicology results were received and showed positive results for fentanyl and phenobarbital. In reviewing the birth records, it was learned the infant was prescribed phenobarbital at the time of his discharge from the hospital; however, there was no medical explanation for the fentanyl.

UCDSS indicated the allegations of DOA/Fatality and Inadequate Guardianship against the mother and father. The investigation conclusion narrative stated the parents could not provide an explanation for the infant's positive toxicology and were aware of safe sleep education when they placed the infant in an unsafe sleeping arrangement. The allegations of PD/AM against both parents were unfounded as UCDSS did not find credible evidence that the parents were under the influence of substances while caring for the subject infant; however, UCDSS did not request the mother complete a drug test despite many reported concerns she had been using drugs. The parents became uncooperative after the initial interviews and it was unknown what services, if any, they utilized.

PIP Requirement

UCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) UCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, UCDSS 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:
UCDSS indicated and closed the investigation.

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:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	There were concerns the mother may have been on heroin at the time of the subject child's death, and under the influence during the investigation. The mother was on probation and the record did not reflect that her probation officer was contacted during this investigation, nor was a drug test requested. The mother signed releases for her medical providers. UCDSS faxed releases to providers but the record did not reflect any information was received from providers.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)

Action:	UCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the (child)ren.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/10/2020 **Time of Death:** 12:09 PM

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

County where fatality incident occurred: Ulster
Was 911 or local emergency number called? Yes
Time of Call: 11:19 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 was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☐ 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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Other Household 1	Grandparent	No Role	Female	54 Year(s)
Other Household 1	Sibling	No Role	Female	5 Year(s)
Other Household 2	Other Adult - Father of Sibling	No Role	Male	28 Year(s)

LDSS Response

UCDSS began their investigation into the incident upon receipt of the SCR report on 11/10/20. They searched SCR history and spoke to the source of the report, the medical examiner's office, law enforcement, hospital staff, the parents, and the maternal grandmother. They conducted several home visits and they assessed the safety of the sibling throughout the investigation. The father of the sibling was incarcerated and efforts to interview him were made, but attempts were unsuccessful. UCDSS notified the sibling's father of the investigation.

Through interviews with the parents it was learned that the infant was born full-term and he was positive for opiates at birth. He was admitted to the NICU and was diagnosed with neonatal abstinence syndrome. He was discharged home on medication, and it was noted he was tongue tied. The mother was allegedly prescribed several medications, all of which the child tested positive for at birth.

The case record reflected that during a telephone conversation with the mother on 11/16/20, the mother slurred her words several times during the conversation. The caseworker noted they could not discern whether this was related to the mother being emotional or something else. The next day on 11/17/20, a subsequent SCR report was received alleging the mother was under the influence of heroin at the time of the subject child's death. Columbia County Family Court then ordered a 1034 investigation with concerns the mother was observed to be "nodding out" and had a history of drug use. Despite these concerns, UCDSS did not request she complete a drug test or verify with medical providers that she was prescribed any medication that may explain these behaviors.

The parents shared that the mother was at home with the infant on the morning of 11/10/20 while the father was at work. The father received a phone call from the mother around 11AM stating the infant was having difficulty breathing. The father advised the mother to call 911, which the mother then did. It was learned the father woke at 5AM and took the infant out of his bassinette to feed a bottle. After feeding the infant, the father placed the infant into bed with the mother. The father reported the mother was awake when the father placed the infant into bed with her. The mother corroborated this information and reported waking up to feed the infant again at 8AM. Following that feeding, she and the infant fell asleep in the bed together. It was around 11AM when she woke to find the infant underneath her. Both parents reported the infant frequently slept in the bed with them despite knowledge of safe sleep practice.

Following initial interviews, the parents refused to cooperate further with UCDSS. UCDSS made attempts to provide mental health and bereavement information to the mother and father as well as substance abuse treatment due to their history of abuse and the infant's positive toxicology at birth. UCDSS exhausted efforts to maintain contact with the parents and gather additional information, to no avail. At the time of this writing, it was unknown where the parents were residing or whether they were engaged in services.

The maternal grandmother reported that she and the parents had a strained relationship due to a new order in family court barring the mother from unsupervised visitation with the sibling. The maternal grandmother expressed concern for the parents' substance abuse but was unable to speak more on the concern as she and the mother were not on speaking terms. UCDSS and a Columbia County Department of Social Services, where the grandmother and sibling resided, checked in with them regularly throughout the investigation. No concerns were present for the safety of the sibling with the grandmother.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Comments: UCDSS adhered to approved protocols for joint investigations by collaborating with law enforcement and notifying the DA's office of the death.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No

Comments: There is no OCFS approved Child Fatality Review Team in Ulster County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
055602 - Deceased Child, Male, 2 Month(s)	056842 - Father, Male, 23 Year(s)	DOA / Fatality	Substantiated
055602 - Deceased Child, Male, 2 Month(s)	056842 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated
055602 - Deceased Child, Male, 2 Month(s)	056841 - Mother, Female, 28 Year(s)	DOA / Fatality	Substantiated
055602 - Deceased Child, Male, 2 Month(s)	056841 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
055602 - Deceased Child, Male, 2 Month(s)	056841 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
055602 - Deceased Child, Male, 2 Month(s)	056842 - Father, Male, 23 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:
Despite efforts from UCDSS, the father of the sibling was not interviewed. UCDSS attempted a home visit; however, the parents would not allow caseworkers in the home. The record did not reflect UCDSS made contact with the mother's medical providers. There were concerns the mother was using heroin and the record did not reflect the mother's probation officer was contacted. The 5yo SS was not observed or interviewed; however, this child resided with the grandmother and had limited, supervised contact with the mother.

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 sibling was previously placed in the care of the maternal grandmother and remained in her care at the time of the investigation. The parents refused to cooperate with UCDSS thus additional service needs could not be explored with 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: The surviving sibling had previously been placed with the maternal grandmother via order of family court.				

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
UCDSS offered services to the family following the death. The parents became uncooperative with UCDSS and it was unknown what services they utilized. Referrals were offered for bereavement counseling and mental health counseling. Substance abuse treatment was discussed and both parents declined a need for treatment. Although the SS had been removed from the mother's care and the subject child was deceased, the record did not reflect UCDSS discussed family planning with the parents.

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:
UCDSS provided the maternal grandmother with resources and referrals for the sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
UCDSS provided resources to the parents. It was unknown if services were utilized as the parents stopped cooperating with UCDSS during the investigation.

History Prior to the Fatality

Child Information

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

10/28/2020	Deceased Child, Male, 1 Months	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 1 Months	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Male, 1 Months	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 1 Months	Father, Male, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
Ulster County Department of Social Services received a report from the SCR alleging the mother and father consumed an unknown substance while caring for the subject child. The parents passed out in the car, leaving the subject child unattended for an unknown length of time. Once awake, the parents were disoriented. A subsequent report was received from the SCR alleging the parents used crack cocaine and heroin while caring for the subject child. They would scream and yell at one another causing the subject child to cry and be distraught.

Report Determination: Unfounded | **Date of Determination:** 11/20/2020

Basis for Determination:
UCDSS' determination stated they observed a bassinet for the subject child, received information from the subject child's primary care provider stating the child was born withdrawing from the mother's prescribed medication, and that on 11/5/20, the mother was drug tested by probation and she tested positive only for her prescribed medication. UCDSS unfounded and closed their investigation as a new investigation regarding the fatality came in and concerns would be further investigated during that report.

OCFS Review Results:
LE and EMS found the parents passed out in their car with the subject child and believed the parents to be under the influence. A belt was found in the front seat of the car without any reasonable explanation. Collateral contacts reported the father “beat” the mother while she was pregnant with the subject child, that the father was not supposed to be living in the home, and that drug paraphernalia such as needles and a “crack pipe” were found outside the home. There were 17 domestic incident reports, of which the mother was the aggressor in 14. The parents failed to show for a scheduled drug test at UCDSS, and the mother refused to sign releases. The record did not reflect UCDSS verified the mother was prescribed the medication in which the subject child tested positive for at birth, or that safe sleep was discussed with the parents. The mother previously had her other child removed when the child was two months old due to the mother’s substance use disorder and domestic violence with that child’s father. The child’s primary care provider informed UCDSS they were concerned the parents needed support and that the parents did not show for their last schedule visit with the subject child. There was no documentation that legal action was discussed or that a consult with the legal department occurred. Domestic violence services were not offered to either parent. With the mother’s history, and several concerns in this case, a safety plan should have been implemented for the subject child.

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

Issue:
Failure to provide safe sleep education/information

Summary:
Although UCDSS noted in the case record that "safe sleep was observed," the record did not reflect the parents were provided with information on safe sleep, including the risks of bed-sharing.

Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:
UCDSS must provide the parent or caregiver with information on safe sleep, including the risks of bed-sharing.

Issue:
Timely/Adequate Seven Day Assessment

Summary:
UCDSS selected a safety decision 2 and should have selected a safety decision 3. LE and EMS found the parents to be under the influence while caring for the subject child. The record did not reflect UCDSS verified the mother was prescribed medications, the mother's other child was removed (when she was two months old) due to her substance use and domestic violence, a collateral contact reported a crackpipe was found outside the home and suspected it belonged to the mother, and there were newly reported concerns of domestic violence with the subject child's father who was not supposed to be living in the home. The parents failed to show for a scheduled drug test with UCDSS on 10/28/21.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Within seven days of receiving a report, UCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Issue:
Assessment as to need for Family Court Action
Summary:
The mother and father had a history of substance use disorder, domestic violence, failed to show for a scheduled drug test, refused to sign releases, and were found passed out in a car with the subject child by LE and EMS and were believed to be under the influence. The mother previously had her other child removed due to substance use and domestic violence concerns. The record did not reflect UCDSS discussed legal action or consulted with their legal department.
Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)
Action:
UCDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:
Appropriateness of allegation determination
Summary:
LE and EMS reported the parents were found slumped over in their vehicle while the subject child was in the back seat. It took LE several attempts of banging on the car windows to wake the parents. The parents appeared to be "out of it" and "very disoriented." EMS evaluated the family and stated they thought the adults appeared to be under the influence, but they could not confirm. The record did not reflect UCDSS confirmed with medical providers that the mother was prescribed medications, nor did UCDSS document they observed the mother's prescription medication.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
UCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the (whichever) Regional Office if further guidance is needed

Issue:
Failure to Offer Appropriate Services
Summary:
Although the mother and father denied a history of domestic violence upon the first interview with the family, UCDSS later learned of multiple domestic incident reports in which the mother was the aggressor. The police were called to the home on 1/19/19 due to a "heated" argument between the mother and father. A collateral contact reported recent incidents of the father "beating" the mother while pregnant. The mother admitted to breaking an order of protection against a past partner, and she was on probation for two different incidents of criminal contempt. The mother called the CW on 11/15/20, and there was no further discussion of domestic violence or the offering of services.
Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation, offer appropriate services to the family or any child believed to be suffering from abuse or maltreatment, or both, or to the family and any child who are part of a family assessment response, and, in offering these services, explain to the family that the child protective service has no legal authority to compel the family to receive services.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/28/2019	Sibling, Female, 3 Years	Mother, Female, 26 Years	Inadequate Guardianship	Far-Closed	No
	Sibling, Female, 3 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 3 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 3 Years	Grandparent, Female, 52 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:

Columbia County Department of Social Services (CCDSS) received a report from the SCR alleging the mother was abusing drugs and was homeless. She took the sibling out of the maternal grandmother's home, where the sibling had been residing.

OCFS Review Results:

CCDSS exhausted efforts to explore and elicit information pertaining to each area of the Family-Led Assessment Guide (FLAG). The FLAG was completed in close consultation with the family prior to completion of the FAR. The case record reflected CCDSS provided information to the family about CPS response options, including the key difference between the two; a discussion was held with the family regarding the key differences. CCDSS investigated all concerns that arose during the investigation. Once all case objectives were met, CCDSS appropriately closed the FAR.

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

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

A report was received by UCDSS from the SCR in 2015 regarding the sibling who was 4-months-old at the time. The report was indicated for Parent's Drug/Alcohol Misuse. The mother was intoxicated and engaged in physical altercations with other adults in the home. The mother was arrested and a safety plan for the sibling was necessary. The father of the sibling received custody in family court and the mother was awarded supervised visitation.

There were multiple closed FAR cases from 2016 related to the mother and father of the siblings inability to appropriately supervise the sibling and for their substance abuse. Evidence was not found to support the allegations. The father of the sibling received custody of the child through family court during this time frame.

Known CPS History Outside of NYS

There was no known history outside New York.

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