Child Fatality Report

Report Identification Number: SY-17-039

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

Issue Date: Jan 25, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased **Jurisdiction:** Broome **Date of Death:** 08/17/2017
Age: 21 day(s) **Gender:** Male **Initial Date OCFS Notified:** 08/17/2017

Presenting Information

An SCR report was made on 8/17/17 alleging early that morning, SM and SF fed the 3-week-old twin children (SC and his SS). SF put the SC down in the bassinet and shortly thereafter, he noticed the SC was unresponsive and gray in color. The parents and the PS brought him into the hospital themselves. The report noted the SC was born premature on 7/27/17 and discharged from the hospital on 8/9/17. He had no other preexisting medical condition and was an otherwise healthy child. All adults in the home were considered alleged subjects. 3 SS (ages 14yo, 3yo, and 3-weeks-old) were listed as having unknown roles.

Executive Summary

On 8/17/2017, an SCR report was made regarding the death of the 3-week-old SC, and Broome County Department of Social Services (BCDSS) was assigned to investigate. The investigation was done collaboratively with LE, as SC died for unknown reasons after he had been swaddled and placed to sleep in the same bassinet as his twin.

BCDSS were already involved with SC and his family in a CPS Services case initiated on 6/23/2017 and an active CPS investigation which began 7/27/2017. The CPS Services case was in response to an IND report regarding SM's drug abuse and the impact on her care of the 3yo SS. BCDSS monitored SM's drug Tx and addressed safety of SC and his twin upon their birth. A safety plan that SM not be alone with the 3yo SS was in place prior to the twins' birth and a Neglect Petition had been filed. SM and SF had not agreed to include the twins as recommended in a safety plan when they were born, and though BCDSS consulted their Legal Department, there was not enough at that time to add them to the petition.

SM, SF, and PS were responsible for the care of SC and the other SS in the home (SC's twin, 3yo SS, and 14yo SS). The adults shared a bed and the twins slept in separate bassinets in the adults' room, but were occasionally placed in the same one. When interviewed, SM, SF, and PS provided consistent accounts of the events leading up to the fatality. Around 4:30AM, after SF fed SC in the adult bed, SM swaddled SC and placed him in the same bassinet as the twin SS, who was also swaddled. The bassinet was observed to have contained "padding" with a "horseshoe type pattern and bend in it," and was secured as evidence by LE. SM said this was not extra padding, and had come with the second-hand bassinet. SM noted she had twisted receiving blankets and put them between the babies but not near their faces. Approximately an hour after she put him down, SM woke to find SC unresponsive. SM denied anything was obstructing SC's airway. SM alerted SF and PS; SF and PS drove SC to the hospital without calling 911 as they felt driving themselves would be faster. SC presented as unresponsive at the hospital and was pronounced deceased.

A safety plan was devised for the 3 SS; SM, SF, and PS were not to be unsupervised with them and they went to stay with identified resource persons. The BCDSS Legal Department was appropriately consulted numerous times throughout the investigation to effectively protect the CHN. The 2 younger SS were eventually removed from the SM and SF's custody in October 2017 with parental consent and placed into FC with the resource person who had been caring for them while the safety plan was in place. The removal was in response to SM's continued drug use despite being in Tx, the unwillingness/inability to protect the SS, and concerns surrounding the fatality once the cause of death was known. In addition to the 3 SS in the home, SC had 5 other SS under the age of 18 (4 of whom were SM's, and 1 of whom was SF's). BCDSS gathered information and documented the locating information of all SS to establish their safety. SM did not have custody of the other 4 SS and there was no known visitation.

The final autopsy report noted the immediate cause of death was asphyxiation due to or a consequence of an inappropriate

bedding/sleep situation. The manner of death was accidental.

LE informed BCDSS the adults were not facing criminal charges as the death was not indicative of criminal intent. LE agreed to apprise BCDSS if there were changes in status throughout the course of their involvement.

Services were offered in response to the fatality. Services for ongoing child welfare concerns remained in place. The CPS investigation also remained open at the time of this fatality report, though documentation reflected the intent to substantiate all allegations, including additional ones identified for SS, as was appropriate. BCDSS completed a thorough investigation and sufficiently responded to evolving circumstances.

PIP Requirement

This review resulted in citations related to casework practice in historical cases. In response, BCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) BCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, BCDSS will review the plan(s) and revise as needed to further address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
    - **Approved Initial Safety Assessment?** Yes
    - **Safety assessment due at the time of determination?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

Determination:

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

Explain:

Though the investigation remained open, BCDSS sufficiently gathered all information necessary regarding the allegations. The Initial Safety assessment was completed with the selection of a Safety Decision #4 (removal to/continued placement in foster care/alternative placement setting) when a formal removal had not taken place; rather, a safety plan was implemented. During this open case, OCFS and the Syracuse Regional Office provided guidance to BCDSS to correct this documentation issue in future investigations.

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

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

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

Explain:
The investigation remained open at the time of the issuance of this fatality report. Further, the CPS Ongoing Services case remained open as well to monitor the provision of services and the children who were placed in Foster Care following the fatality.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/17/2017 **Time of Death:** 06:09 AM

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

County where fatality incident occurred: Broome
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	Male	21 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	49 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	21 Day(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	43 Year(s)
Other Household 1	Other Adult - Eldest Sibling's Legal Guardian	Alleged Perpetrator	Female	59 Year(s)
Other Household 1	Sibling	Alleged Victim	Male	14 Year(s)

LDSS Response

BCDSS initiated the investigation into the SC's death upon receipt of the associated SCR report. BCDSS noted the report was subsequent to an open CPS investigation as well as a CPS Services case, and carried over relevant information. BCDSS immediately collaborated with pertinent collateral contacts and conducted a joint investigation with LE.

BCDSS documented SC and his twin were both born positive for methadone 3 weeks prior. BCDSS was involved with the family when the twins were born, as an SCR report was made in response to the positive toxicology. BCDSS was in the midst of that investigation and documented the high frequency in which SM tested positive for various illicit drugs and alcohol throughout her pregnancy, and were involved with services in response to this at the time of the SC's death. SM's drug use affecting her ability to care for CHN had been a consistent theme since the time her eldest CH, now age 14, was nearly 1yo.

Initially, BCDSS was informed the SC died for unknown reasons after he was placed to sleep, swaddled, in the same bassinet as the twin SS. Between interviews with the SM, SF, and PS, BCDSS learned all 3 adults shared a bed on the night of the fatality and the twins slept in the same room in separate bassinets. The 3yo SS went to bed sometime between 8:30 and 10PM the night prior. SF fed the SC from the adults' shared bed around 4:30AM (where he was in between SM and PS), then handed SC to SM before going back to sleep. SM said she put SC in the same bassinet as the twin SS as she knew SS would wake shortly thereafter to eat; this was around 4:30AM. SM then went back to bed. SM checked on the twins around 5:30AM and alerted SF that SC had blood on his nose and was cold to the touch. They reported not having called 911 as they felt they could arrive at the hospital faster if they drove. SF and PS drove SC to the hospital and brought along the 3yo SS, reportedly to comply with the safety plan that SM not be left alone with the 3yo. SC arrived unresponsive at the hospital and was unable to be revived.

Within 24 hours, BCDSS gathered and documented information regarding all SS. BCDSS consulted their Legal Department on the date of the fatality. It was determined a safety plan was necessary for the 3 SS in the home, and if the family could not agree on one, a formal removal would be requested. Though initially reluctant, the family made a safety plan. BCDSS spoke with the identified resources of the 2 younger SS, confirmed safe sleep and other provisions, and assessed other areas of safety and risk through conversations and evaluations of the homes. BCDSS worked with the eldest SS's legal guardian (LG), who shared custody with SM, to facilitate a place for him to stay. The following day, the family protested the continuation of a safety plan without a court order. BCDSS did then present the matter at Family Court, where SM and SF were present. Once at Court, the parents agreed to keep the safety plan in place for the time being. BCDSS monitored while provisions of the safety plan changed during the case.

BCDSS oversaw the safety plan and modified it when necessary by requesting the parents' consent to place the SC's twin and the 3yo SS into FC. This occurred at a later time while the investigation remained open. After consenting, the 2 SS did enter FC but remained with the person who was caring for them as a safety plan in response to the fatality.

BCDSS noted they had advised SM, SF and PS of recommended safe sleep practices after the birth of the twins, during the open investigation and services cases. BCDSS was diligent with frequent consultations with supervisors and the Legal

Department to address safety and risk throughout involvement in the investigation and CPS Services cases. This was sufficiently documented to reflect the thorough casework practice that was completed throughout BCDSS' involvement.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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: This case was reviewed by the Broome County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042242 - Deceased Child, Male, 21 Days	042504 - Father, Male, 49 Year(s)	DOA / Fatality	Pending
042242 - Deceased Child, Male, 21 Days	042504 - Father, Male, 49 Year(s)	Inadequate Guardianship	Pending
042242 - Deceased Child, Male, 21 Days	042506 - Mother, Female, 33 Year(s)	DOA / Fatality	Pending
042242 - Deceased Child, Male, 21 Days	042507 - Unrelated Home Member, Female, 43 Year(s)	DOA / Fatality	Pending
042242 - Deceased Child, Male, 21 Days	042506 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
042242 - Deceased Child, Male, 21 Days	042507 - Unrelated Home Member, Female, 43 Year(s)	Inadequate Guardianship	Pending
042501 - Sibling, Male, 21 Day(s)	042506 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
042501 - Sibling, Male, 21 Day(s)	042504 - Father, Male, 49 Year(s)	Inadequate Guardianship	Pending
042501 - Sibling, Male, 21 Day(s)	042507 - Unrelated Home Member, Female, 43 Year(s)	Inadequate Guardianship	Pending
042502 - Sibling, Female, 3 Year(s)	042506 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
042502 - Sibling, Female, 3 Year(s)	042504 - Father, Male, 49 Year(s)	Inadequate Guardianship	Pending
042503 - Sibling, Male, 14 Year(s)	042901 - Other Adult - Eldest Sibling's Legal Guardian, Female, 59 Year(s)	Lack of Supervision	Pending
042503 - Sibling, Male, 14 Year(s)	042506 - Mother, Female, 33 Year(s)	Educational Neglect	Pending

042503 - Sibling, Male, 14 Year(s)	042901 - Other Adult - Eldest Sibling's Legal Guardian, Female, 59 Year(s)	Inadequate Guardianship	Pending
042503 - Sibling, Male, 14 Year(s)	042901 - Other Adult - Eldest Sibling's Legal Guardian, Female, 59 Year(s)	Educational Neglect	Pending
042503 - Sibling, Male, 14 Year(s)	042506 - Mother, Female, 33 Year(s)	Lack of Supervision	Pending
042503 - Sibling, Male, 14 Year(s)	042506 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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 safety 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	☒	☐	☐	☐

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: The 2 youngest SS were removed upon consent of the SM and SF approximately 2 months after the fatality.				

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:**
08/18/2017	There was not a fact finding	Adjourned
Respondent:	042504 Father Male 49 Year(s)	
Comments:	An application for pre-petition temporary removal was filed concerning the 3yo SS, the SC's twin, and the SC (who predeceased the filing of the neglect petition). In their petition, BCDSS expressed the 2 SS	

	required immediate protection in the form of temporary removal from their home prior to the filing of a petition due to the standing concerns in the previously filed neglect petition, the latest concerns regarding the SC and SS, and the investigation into SC's death. This application for removal was in response to the parents' refusal to agree to the safety plan that the children remain out of the home in the care of other adults during the investigation. At court to address this application, the parents agreed to extend the safety plan as BCDSS requested and a removal was not deemed necessary at that time.

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
08/18/2017	There was not a fact finding	Adjourned
Respondent:	042506 Mother Female 33 Year(s)	
Comments:	An application for pre-petition temporary removal was filed concerning the 3yo SS, the SC's twin, and the SC (who predeceased the filing of the neglect petition). In their petition, BCDSS expressed the 2 SS required immediate protection in the form of temporary removal from their home prior to the filing of a petition due to the standing concerns in the previously filed neglect petition, the latest concerns regarding the SC and SS, and the investigation into SC's death. This application for removal was in response to the parents' refusal to agree to the safety plan that the children remain out of the home in the care of other adults during the investigation. At court to address this application, the parents agreed to extend the safety plan as BCDSS requested and a removal was not deemed necessary at that time.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
10/17/2017	There was not a fact finding	Direct Custody Transferred toContinued with Non-Relative (Article 10)
Respondent:	042504 Father Male 49 Year(s)	
Comments:	This Neglect Petition concerned the 14yo and 3yo SS, the SC's twin, and the predeceased SC. Allegations included IF/C/S, LMC, LS, IG, and PD/AM. The petition mentioned ongoing concerns evident from prior Neglect Petitions and noted new concerns surrounding the SC's birth and death. Further, SM continued to test positive for drugs and alcohol. It was noted the 14yo SS' whereabouts were unknown following the safety plan put into place for him around 8/17/17. The parents could not maintain stable housing. Concerns for SF were his failure and/or inability to take adequate measures to protect the children. In the petition, BCDSS noted the 2 youngest SS' continuation in or return to the parents' care would be contrary to their best interests. A removal was granted and court remained ongoing. The eldest SS remained in the care of SM.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
10/17/2017	There was not a fact finding	Direct Custody Transferred toContinued with Non-Relative (Article 10)
Respondent:	042506 Mother Female 33 Year(s)	
Comments:	This Neglect Petition concerned the 14yo and 3yo SS, the SC's twin, and the predeceased SC. Allegations included IF/C/S, LMC, LS, IG, and PD/AM. The petition mentioned ongoing concerns evident from prior Neglect Petitions and noted new concerns surrounding the SC's birth and death. Further, SM continued to test positive for drugs and alcohol. It was noted the 14yo SS' whereabouts were unknown following the safety plan put into place for him around 8/17/17. The parents could not maintain stable housing.	

	Concerns for SF were his failure and/or inability to take adequate measures to protect the children. In the petition, BCDSS noted the 2 youngest SS' continuation in or return to the parents' care would be contrary to their best interests. A removal was granted and court remained ongoing. The eldest SS remained in the care of SM.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☒	☐	☐	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☒	☐	☐	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐	☐
Health care	☒	☐	☐	☐	☐	☐	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☒	☐	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☒	☐	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☒	☐	☐	☐	☐	☐	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
Foster Care Services were provided to the children as needed when appropriate (following the fatality). Services were offered for the family in regard to trauma associated with the fatality but it was not noted that any services were accepted.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Foster Care Services were provided to the family as needed when appropriate (following the fatality). Specific services

related to the fatality were offered multiple times but the record did not reflect that any of those services were accepted or utilized while the case was open.

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? 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)	Status/Outcome	Compliance Issue(s)
07/27/2017	Deceased Child, Male, 0 Days	Mother, Female, 33 Years	Inadequate Guardianship	Pending	No
	Sibling, Male, 0 Days	Mother, Female, 33 Years	Inadequate Guardianship	Pending	
	Sibling, Male, 0 Days	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Pending	
	Deceased Child, Male, 0 Days	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Pending	
	Sibling, Female, 3 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Pending	
	Sibling, Female, 3 Years	Mother, Female, 33 Years	Inadequate Guardianship	Pending	

Report Summary:
An SCR report alleged SM gave birth to twin boys (SC and SS) on the date of the report, born at 35.5 weeks' gestation. The SM was hospitalized for about a month prior due to high risk pregnancy from substance abuse, homelessness, and

CPS history. SM left her drug rehab and was testing positive for several drugs prior to hospitalization. It was noted SM had multiple children previously removed who remained in placement elsewhere, but was believed to have another young child (3yo SS) still in her custody and thus at risk. It was further noted the newborns remained hospitalized due to prenatal exposure to methadone.

Determination: Undetermined

OCFS Review Results:
BCDSS conducted a thorough investigation into the reported allegations as well as new concerns that arose surrounding and after the fatality.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/16/2017	Sibling, Male, 14 Years	Mother, Female, 33 Years	Educational Neglect	Indicated	No
	Sibling, Male, 14 Years	Other Adult - LG of the now 14yo SS, Female, 59 Years	Educational Neglect	Indicated	
	Sibling, Male, 14 Years	Other Adult - LG of the now 14yo SS, Female, 59 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 14 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	

Report Summary:
An SCR report alleged the 14yo SS was out of control, did not attend school regularly, drank alcohol, smoked, and would leave the home without notifying his LG of his plans or location. On 7/15/17, the SS drank alcohol and became intoxicated. The LG was unable to provide the SS with the higher level of care he required. The allegation of EdN was added upon learning of the concern, and both allegations were added against SM who was a regular caretaker and similarly was not mitigating concerns.

Determination: Indicated | **Date of Determination:** 10/13/2017

Basis for Determination:
BCDSS found SM and SS's LG did not ensure SS was going to school, nor did they file missing persons reports in a timely fashion when the SS continuously left their care at either home. At the time the investigation closed, the SS remained in the home of SM who had an open CPS services case.

OCFS Review Results:
Many efforts were made to assess SS's safety within 24 hours, but BCDSS was not successful at making contact until after that period. BCDSS made sufficient collateral contacts. BCDSS included this SS in the safety plan devised with the family as a result of SC dying of suspicious reasons while this investigation was open.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/21/2017	Sibling, Female, 3 Years	Unrelated Home Member, Female, 28 Years	Inadequate Guardianship	Indicated	Yes
	Other Child - Female UHM's Child, Female, 13 Years	Father, Male, 49 Years	Inadequate Guardianship	Indicated	

Sibling, Female, 3 Years	Sibling, Male, 28 Years	Inadequate Guardianship	Indicated
Other Child - Female UHM's Child, Female, 10 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Other Child - Female UHM's Child, Female, 13 Years	Unrelated Home Member, Female, 28 Years	Inadequate Guardianship	Indicated
Other Child - Female UHM's Child, Female, 10 Years	Unrelated Home Member, Female, 28 Years	Inadequate Guardianship	Indicated
Other Child - Female UHM's Child, Female, 10 Years	Father, Male, 49 Years	Inadequate Guardianship	Indicated
Sibling, Female, 3 Years	Father, Male, 49 Years	Inadequate Guardianship	Indicated
Other Child - Female UHM's Child, Female, 13 Years	Sibling, Male, 28 Years	Inadequate Guardianship	Indicated
Other Child - Female UHM's Child, Female, 10 Years	Sibling, Male, 28 Years	Inadequate Guardianship	Indicated
Sibling, Female, 3 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Female, 3 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Other Child - Female UHM's Child, Female, 13 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Other Child - Female UHM's Child, Female, 13 Years	Father's Partner, Female, 42 Years	Inadequate Guardianship	Indicated
Other Child - Female UHM's Child, Female, 10 Years	Father's Partner, Female, 42 Years	Inadequate Guardianship	Indicated
Sibling, Female, 3 Years	Father's Partner, Female, 42 Years	Inadequate Guardianship	Indicated

Report Summary:
An SCR report alleged SM abused drugs to impairment while being the sole caretaker of the 3yo SS. SF, PS (SF's girlfriend), and two other adults in the home (OA1 and OA2) were all aware of SM's drug use and failed to intervene to protect the SS (OA1 and OA2 were the parents of two unknown children). SM, SF and PS were aware the unknown other parents were bagging and selling illicit drugs in the home, failing to protect the SS.

Determination: Indicated | **Date of Determination:** 06/29/2017

Basis for Determination:
BCDSS found during the investigation, while pregnant, SM had several positive drug screens. SM alleged the reason for her positive screens was accidental drug usage from roommates packing/selling drugs in the home. BCDSS did not find evidence of such. SM and SF were both sole caretakers of the 3yo SS; SF was aware of SM's extensive drug history and its negative impact on SS, and was previously cautioned about leaving the 3yo SS alone in her care. Allegations against the OA and their respective other CHN were Unsub due to lack of evidence.

OCFS Review Results:
BCDSS saw all household members; SF's adult son, daughter-in-law, and her CHN resided with them. BCDSS interviewed all adults and OA's CHN; efforts were made to interview the SS but parents refused. BCDSS sought assistance from LE to evaluate allegations and assess safety within 24 hours. BCDSS consulted the Legal Department at pertinent points in the investigation and appropriately filed neglect petitions, indicated the report, and opened for services. Some questions on the RAP were inaccurate.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP incorrectly stated SM had no MH diagnoses, demonstrated developmentally appropriate expectations of her children, and attended to/prioritized the needs of her children above her own needs/desires. SM admitted to MH diagnoses. She was indicated for misusing drugs while caring for SS, which contradicted the responses to the other two questions.

Legal Reference:
18 NYCRR 432.2(d)

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/23/2016	Sibling, Male, 13 Years	Other Adult - LG of the now 14yo SS, Female, 58 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 13 Years	Other Adult - Unrelated Adult , Female, 42 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 13 Years	Other Adult - Unrelated Adult , Female, 42 Years	Inadequate Guardianship	Unfounded	

Report Summary:
An SCR report alleged an adult (OA) had recently had children removed from her care due to neglect (alcohol misuse). The SS's LG was aware the OA was an inappropriate caregiver, though she left the 13yo SS in the OA's care. At one point, the OA was intoxicated and was unable to adequately care for the SS.

Determination: Unfounded | **Date of Determination:** 01/05/2017

Basis for Determination:
The SS, LG, and OA denied SS was babysat by the OA after her CHN were removed. No additional concerns were revealed for the CHN during the investigation.

OCFS Review Results:
BCDSS appropriately addressed all concerns and completed timely and accurate safety assessments. BCDSS made efforts to speak with all persons named on the report and biological parents. Some questions were answered incorrectly on the RAP.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP indicated CHN had not been in the care/custody of other caregivers (though they had) and identified no MH diagnosis for the SS's LG (though she admitted to MH diagnoses).

Legal Reference:
18 NYCRR 432.2(d)

Action:
BCDSS will accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Issue:

Failure to provide notice of report

Summary:

Documentation does not reflect whether any adults were provided Notice of Existence letters.

Legal Reference:

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

Action:

BCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/23/2016	Sibling, Female, 0 Days	Mother, Female, 32 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Female, 0 Days	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:

An SCR report alleged SM gave birth to a SS on the date of the report. It was noted SM had 5 of her other CHN removed from her care due to substance abuse history, who had not been returned to her care. SM had a long history of substance abuse, and tested positive for drugs during this pregnancy. There was concern SM was unable to care for the newborn. Miscellaneous information noted the SS was not showing withdrawal symptoms at the time, and the toxicology reports had not yet been completed. SM stated she was planning to give the newborn up for adoption as she did not want the baby.

Determination: Indicated | **Date of Determination:** 09/20/2016

Basis for Determination:

The newborn SS spent time in the Neonatal Intensive Care Unit for withdrawal from prescription and illicit medications which SM also tested positive for during pregnancy. Prior to delivery, SM planned on adopting out the newborn. A relative came to adopt the SS; BCDSS found those caregivers appropriate. They were in process of adopting at the time the case closed; BCDSS submitted a COI and were relieved of involvement by the Family Court judge. BCDSS found the SM's drug use had a direct negative impact on the SS.

OCFS Review Results:

BCDSS appropriately sought legal advice when SM denied access to another SS (age 2) in her care, and an Order to Produce was not able to be obtained. BCDSS maintained contact with the Legal Department at pertinent times throughout the investigation. BCDSS consulted a service provider who had seen that SS to assess her safety after making diligent efforts to see her and her home environment. BCDSS went over and assessed safe sleep recommendations with the adoptive parents.

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

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The 7-day safety assessment noted a safety plan was unnecessary, but spoke of an active safety plan that could result in protective removal if not followed. The investigation conclusion safety assessment noted a protective removal or continued placement was necessary. If accurate, the case should have remained open until certain that the SS was adequately protected or opened a services case.

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 in order to reflect case circumstances with regard to safety.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/13/2016	Sibling, Male, 13 Years	Other Adult - LG of the now 14yo SS, Female, 58 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	Sibling, Male, 13 Years	Other Adult - LG of the now 14yo SS, Female, 58 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 11 Years	Other Adult - LG of the now 14yo SS, Female, 58 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 13 Years	Other Adult - LG of the now 14yo SS, Female, 58 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 11 Years	Other Adult - LG of the now 14yo SS, Female, 58 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Sibling, Male, 11 Years	Other Adult - LG of the now 14yo SS, Female, 58 Years	Inadequate Guardianship	Unfounded	

Report Summary:
An SCR report alleged 2 SS (ages 13 and 11) had a history of criminal behaviors and were not mature enough to be left home alone unsupervised. Their LG was aware yet left them home alone on a regular basis. The home was allegedly in deplorable conditions, with animal urine and feces on the floors, moldy food strewn around, and a bed bug infestation. The home was without power for the 3 weeks prior to the report, with no alternate heating source and frigid temperatures at night. The CHN had not bathed in the 3 weeks prior to the report.

Determination: Unfounded | **Date of Determination:** 07/06/2016

Basis for Determination:
The CHN were reported not to have criminal behaviors requiring a higher level of supervision. At times they were left alone at home after school until their LG got home from work. The LG planned for alternate caregivers when she worked late. The home was without electricity for several weeks for failing to pay the bill, and the family stayed at the home for about a week while without power, though it did not appear outside temperatures made it unsafe. The family stayed with relatives until the power was turned back on. On multiple home visits, the home was observed to be above minimal standards.

OCFS Review Results:
BCDSS addressed the allegations and made efforts to speak with biological parents. The safety assessments were accurate, but the 7-day safety assessment was 11 days overdue. BCDSS did not adequately assess safety within the first 24 hours. Only the 11yo CH was seen, and was home alone, and CW did not ask any safety-related questions to assess his safety being home alone despite the allegations. A supervisor directed the CW to follow up on Monday (3 days later), and no effort was made to contact the LG prior to that time. There was no check of CPS history recorded.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-Day Safety Assessment was not completed on time.

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

Action:
BCDSS will complete all safety assessments in the amount of time as required by NYS SSL.

Issue:
Timely/Adequate 24 Hour Assessment
Summary:
BCDSS did not adequately assess safety within the first 24 hours. Only the 11yo SS was seen, and was home alone, and CW did not ask any safety-related questions to assess his safety being home alone despite the allegations. A supervisor directed the CW to follow up on Monday (3 days later), and no effort was made to contact the SS's LG.
Legal Reference:
SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:
BCDSS will adequately assess safety of children respective to case circumstances within 24 hours of every SCR report.

Issue:
Review of CPS History
Summary:
There was no documentation of a CPS history check for the family.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within five business days of report, BCDSS will review and document all CPS record(s) that apply to the prior reports where the current report involves a subject of the report, a child named in the report or a child's sibling named in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/13/2015	Sibling, Male, 10 Years	Other Adult - LG of the now 14yo SS, Female, 57 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 12 Years	Other Adult - LG of the now 14yo SS, Female, 57 Years	Inadequate Guardianship	Unfounded	

Report Summary:
An SCR report alleged the 10 and 12yo SS's LG had smacked the CHN in the face and pulled their hair. About 2 weeks prior, the LG hit the 10yo so hard he blacked out. It was also alleged the eldest SS found a drug pipe in the couch at home, and there was a bug infestation in the home resulting in the CHN being covered in bug bites.

Determination: Unfounded | **Date of Determination:** 10/05/2015

Basis for Determination:
BCDSS found no safety hazards or other concerns in the home. CHN interviewed denied any issues in the home. The 12yo stated the LG hit the 10yo only; the 10yo denied physical discipline, as did the LG. Collateral contacts did not report any concerns. The 12yo disclosed concerns for LG's adult son but there was no credible evidence to substantiate the concerns.

OCFS Review Results:
Multiple family members including the 10yo CH disclosed SM's boyfriend (SF) hit the 10yo CH in the face. Discipline was discussed with the SF and he denied using physical discipline on the CH. Further, it appeared BCDSS found the CH credible, but they did not adequately follow up on the concern with collaterals (such as the school and Dr.) regarding possible suspicious injuries. BCDSS adequately explored the rest of the allegations, and interviewed all children and their biological parents (except one father, though efforts were made).

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

A secondary caretaker was not identified despite other adults noted to have been caretakers of the CHN. The RAP indicated CHN had not been in the care/custody of other caregivers (though they had), and also identified no MH diagnosis for the SS's LG (though she said she did have MH diagnoses).

Legal Reference:

18 NYCRR 432.2(d)

Action:

BCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Issue:

Determination of Nature, Extent and Cause of Conditions (Report)

Summary:

In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. When the 10yo SS disclosed physical discipline by SF, it was not adequately investigated by following up with collaterals upon which a determination could have been made regarding a possible new allegation.

Legal Reference:

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

Action:

BCDSS will explore any new concerns as they arise with all necessary parties in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/28/2015	Sibling, Male, 10 Years	Other Adult - Adult son of the now 14yo SS's LG, Male, 31 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 10 Years	Other Adult - LG of the now 14yo SS, Female, 57 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 10 Years	Other Adult - Adult son of the now 14yo SS's LG, Male, 31 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 12 Years	Other Adult - Adult son of the now 14yo SS's LG, Male, 31 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 12 Years	Other Adult - Adult son of the now 14yo SS's LG, Male, 31 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 10 Years	Other Adult - LG of the now 14yo SS, Female, 57 Years	Lack of Medical Care	Unfounded	

Report Summary:

An SCR report alleged the SS (age 10 at the time) had a medical diagnosis and was prescribed medication. There was a chronic issue with the SS not receiving his morning dose of medication. As a result, the SS's behavior was deteriorating.

Determination: Unfounded | **Date of Determination:** 06/25/2015

Basis for Determination:

BCDSS found no negative impairment to the SS as a result of possible improper dosing of prescribed medication. BCDSS saw that SS' LG got the prescription changed so the school could administer both doses as prescribed. The SS's doctor noted no concerns. BCDSS found no evidence to substantiate allegations made against the LG's adult son as far as drug or alcohol use around the children.

OCFS Review Results:
BCDSS appropriately explored the allegations along with general safety and risk. Though they were sent Notice of Existence letters, 3 biological parents who were listed on the report were not attempted to be contacted for an interview, one of whom the children regularly visited (SM).

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

Issue:
Adequacy of face-to-face contacts with the child and/or childs parents or guardians

Summary:
Efforts were not made to interview 3 biological parents listed on the report, and one of them (SM) was known to have regular contact with the children. Interviewing SM would have likely given the CW important information necessary to make an adequate assessment of the children's safety and risk.

Legal Reference:
432.1 (o)

Action:
BCDSS will make efforts to make casework contacts with biological parents and/or other persons named in a report. Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians.

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
No secondary caretaker was identified when it was known that LG's adult son (who claimed to be the SS's real biological father) had a regular caretaking role for the SS prior to and during the investigation. He was also an alleged subject.

Legal Reference:
18 NYCRR 432.2(d)

Action:
BCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/09/2014	Sibling, Female, 9 Months	Mother, Female, 30 Years	Inadequate Guardianship	Indicated	No
	Sibling, Female, 9 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 9 Months	Father, Male, 46 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:
An SCR report alleged that on 12/9/14, SM overdosed on opiates and was not breathing for a period of time. The SF and SS (who was 9 months old at the time) were home at the time of the incident. The report noted SM's history of drug abuse and that she had used the week prior. There were safety concerns for the SS, as SM was sometimes left to care for the SS when the SF was not home, and SM feared she would leave her drug needles out and accessible to the SS. A subsequent report was made on 12/31/14, alleging both SM and SF abused drugs while being sole caretakers of SS, and became impaired and unable to provide adequate care for her. This report was consolidated with the initial investigation.

Determination: Indicated | **Date of Determination:** 01/30/2015

Basis for Determination:
BCDSS confirmed the events occurred as alleged regarding the SM's overdose of drugs in the presence of the SS. BCDSS found the SF was able to remain the primary caretaker of the SS while the SM sought drug treatment. BCDSS found no evidence of drug or alcohol misuse by the SF. SF was aware of the concerns and expressed he would ensure the SS's protection by not letting her be unsupervised with SM or allow any drugs in the home. BCDSS appropriately consulted the Legal Department when SF later allowed SS to be unsupervised with SM; the attorney advised that based on the circumstances there was not enough evidence at that time to compel a safety plan that the parents were not in agreement with.

OCFS Review Results:
BCDSS appropriately responded to concerns in consultations with the family and agency staff (including the legal department when necessary). BCDSS promptly responded to the subsequent report, and documented their response. BCDSS conducted a complete investigation and accurately determined the report.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/08/2014	Sibling, Female, 8 Years	Other Adult - Legal Guardian of the now 11yo SS, Female, 37 Years	Inadequate Guardianship	Unfounded	Yes
	Other Child - Biological CH of the now 11yo SS's Legal Guardian, Female, 11 Years	Other Adult - Legal Guardian of the now 11yo SS, Female, 37 Years	Inadequate Guardianship	Unfounded	

Report Summary:
An SCR report alleged a caregiver was allowing a male parent substitute (PS), a registered sex offender, to have regular and consistent contact with one of the SS (now age 11) along with another child. The report noted the caregiver's children were previously removed for similar reasons, and she had been court-ordered not to allow this man, among others, to have contact with the children.

Determination: Unfounded | **Date of Determination:** 01/29/2015

Basis for Determination:
The investigation revealed the man in question was not a registered sex offender and there were no restrictions against him regarding children. The children were interviewed and denied any allegations of sexual abuse. It was determined there were no safety concerns for the children, though it was noted there was a similar investigation 12 years prior naming both caregivers and other children; the caregiver confirmed she had had children removed from her care for allowing them around sex offenders.

OCFS Review Results:
BCDSS contacted LE at the onset of the SCR report to inquire whether the PS was on the sex offender registry or had any restrictions. The case type did not require a joint investigation as it was not alleged that sex abuse was occurring. BCDSS attempted to contact each child's absent parent, to no avail. BCDSS interviewed all necessary parties and collateral contacts, completed timely and accurate assessments, and appropriately determined the report based on information documented.

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

Issue:
Failure to provide notice of report

Summary:
2 of the 4 Notice of Existence Letters to adults were not sent out within the required 7-day time-frame.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)
Action:
BCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/30/2014	Sibling, Female, 6 Months	Father, Male, 46 Years	Parents Drug / Alcohol Misuse	Unfounded	No
	Sibling, Female, 6 Months	Father, Male, 46 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 6 Months	Father, Male, 46 Years	Lack of Supervision	Unfounded	

Report Summary:
An SCR report alleged SF was the sole caregiver for the SS, 6 months old at the time of the report. SF had a history of drug abuse, and while impaired or out seeking drugs, he often left the SS home alone with no supervision, for at least a half hour or more. The report noted the SM was incarcerated at the time.

Determination: Unfounded | **Date of Determination:** 10/13/2014

Basis for Determination:
Though the SF would not go for a drug screening, he appeared to be sober and not under the influence of any substances at the time of each unannounced visit. Collateral contacts stated SF appropriately supervised the SS and never left her home alone, nor were they aware of any drug use in the home. SF denied the allegations, and BCDSS found no credible evidence to substantiate the allegations. There were no safety concerns for the SS at the time the case closed.

OCFS Review Results:
BCDSS adequately assessed 24-hour safety and determined the SS was protected. BCDSS also went over safe sleep with the person who was caring for the SS at the time, as well as with the SF. BCDSS interviewed the SM in jail. BCDSS followed up with additional unannounced visits when the SM was released from jail, as she was incarcerated for drug-related reasons. BCDSS gathered information from contacts who had direct contact with the family and accurately determined the report based on documented information.

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

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

Between 2003 & 2014, SM was an alleged subject in reports of maltreatment regarding her CHN 19 times, and was indicated 11 times. Throughout the years, consistent concerns were for SM's ongoing substance abuse negatively impacting her CHN in the form of IG, LS, IF/C/S, and LMC. These trends continued into the present. In 2003, a Neglect Petition was filed against SM regarding the eldest SS and she was required to participate in Preventive Services. She was the subject of another Neglect Petition in 2008 regarding 4 SS, and again was required into services, though the same concerns continued. BCDSS often worked to incorporate BFs when their information was known, and included parents, relatives, and non-relative resources when alternate caregivers were required at times of serious safety concerns. The eldest SS's BF was a non-confirmed subject on 2 of the 2003 reports then was no longer involved. The 2nd eldest SS's BF had no role in most of the 2008 reports; BCDSS attempted to engage him especially at pertinent times. SF was a non-confirmed subject once during this period, in 2014, regarding the now 3yo SS.

Some reports during this period were against adults other than biological parents, due to the SS remaining outside the care of SM. In 2009, the 4th SS was a non-confirmed maltreated child for IG & L/B/W against her LG. Also in 2009, the FM &

FF of the 2nd eldest SS were IND for IG & LS of him. In 2010 & 2012, the LG of the eldest 2 SS was a non-confirmed subject of COIs.

Known CPS History Outside of NYS

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

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 06/29/2017

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

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

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

Services Provided

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

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? 13 days				
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?	☐	☐	☒	☐

Required Action(s)

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

Issue:	Adequacy of case recording in FASP
Summary:	The 2 CHN who were placed in Foster Care on 10/18/2017 were not properly tracked in CONNECTIONS; therefore, the wrong FASPs were generated and did not capture all of the pertinent information needed for CHN in Foster Care. This was a matter of documentation and not inadequate practice, as there were no issues in BCDSS' practice regarding the CHN and family with respect to the changes in circumstances.
Legal Reference:	18 NYCRR 428.6(a)
Action:	BCDSS will accurately record information about family members in receipt of child welfare services and assist with the applicable evaluations and assessments of the family in Family Assessments and Service Plans so as to accurately document activities pertaining to the child(ren)'s permanency planning goal(s).

Preventive Services History

6/28/08-10/13/08 Preventive Services opened, but no documentation of any services provided. Intake note stated SM was minimally meeting needs of SS but she needed assistance, was overwhelmed, & degree of care was at risk of being compromised.

10/13/08-4/22/10 CPS Services mandated after IND reports & removal of 4 SS. SM's drug use impaired her judgment & negatively influenced providing SS adequate supervision, medical care, stable housing, and food. Her failure to recognize the seriousness and negative impact inhibited progress at times. FASPs showed little to no progress & SM's inability/unwillingness to achieve reunification. Efforts were made to engage BFs; not all were willing/able to be engaged. BCDSS supervised SM's visitation & facilitated sibling visits. SM completed parenting classes, but financial & housing situations did not improve & drug use worsened. 1 year later, after not meeting goals, SM stated she wanted SS in Article 6 custody of their caregivers. Shortly thereafter, custody was established for 3 SS; 1 went into permanent care of her BF.

2/25/14-5/30/14 Preventive Services opened, concerns SM gave birth to SS, born positive for drugs, & other SS were not in her care due to neglect. BCDSS monitored SM's drug Tx. Case closed as SM continued case management services through a recovery program & was cooperative with their home visits/program requirements.

6/29/17 CPS Services mandated following a Neglect Petition filed regarding the 3yo SS & a temporary order of supervision. BCDSS was initially involved to monitor SM's compliance with drug Tx due to this being an ongoing concern over the preceding 14 years - the main contributing factor as to why none of her other 5 children were any longer in her care. It was also known SM was pregnant and soon expecting twins. The Preventive worker went over safe sleep prior to the birth of the twins and observed separate bassinets for them. Upon their birth, BCDSS advised SM not to be alone with the twins (in addition to the 3yo SS which was court-ordered). BCDSS again went over safe sleep with SM though she refused to sign any agreement by which to abide. Workers consulted the legal department about whether they were able to prevent placement of the newborns due to the concern for continued drug use; preventive efforts continued. The focus of services changed when the SC died due to maltreatment shortly thereafter. The new safety plan (2 youngest SS being cared for by alternate caregivers outside the home) was monitored by BCDSS who also monitored SM's regular drug screens; BCDSS regularly consulted the legal department and documented court activity. Services continued through the time the 2 SS were eventually removed per the parents' consent on 10/18/17. BCDSS facilitated supervised visitation.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

Foster Care Placement History

The 2nd eldest SS entered foster care after SM consented to his removal on 10/7/08. The 3 other SS were not in need of FC services as alternate caregivers were available to care for them, and though BCDSS petitioned the court for their removal, they were placed in non-LDSS custody with their caregivers. Article 6 custody was eventually established for those other CHN years later. FC services for the 2nd eldest SS ended on 5/6/2009 at which point it appeared he was released under non-LDSS custody to the eldest SS's legal guardian. That guardian later obtained Article 6 custody of the SS (as well as the other SS, still in her care under non-LDSS custody, on 12/7/2009).

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/01/2016	There was not a fact finding	CustodyGuardianship assigned to relative or non-relative (Article 6 non-foster care)
Respondent:	None	

Comments:	A non-relative resource applied for Article 6 custody of a newborn SS against the SM. SM had agreed to the resource adopting the SS. A court-ordered investigation was ordered to conduct a home study on the petitioner. It was noted an adoption was pending the petitioner being awarded custody.

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/12/2017	There was not a fact finding	Order of Supervision
Respondent:	042504 Father Male 49 Year(s)	
Comments:	Neglect petition filed by BCDSS concerned the 3yo female SS following findings in the CPS investigation initiated 4/21/17. Concerns were for IF/C/S, IG, LS, and PD/AM, in addition to extensive indicated CPS history involving the 3yo child and prior siblings. Information was provided regarding multiple positive drug and alcohol screens for SM throughout her pregnancy with twins (included SC). SM and SF had refused to cooperate with BCDSS and BCDSS sought court intervention to protect the SS and address the concerns. SM and SF entered general denial and the matter was rescheduled for pre-trial conference. On 7/3/17 it was ordered that: BCDSS was to have supervision over SM, SF and the 3yo SS; the SS was not to be left unsupervised with SM, and the SF was to supervise all contact between SS and SF. A temporary order of supervision was put into place.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/12/2017	There was not a fact finding	Order of Supervision
Respondent:	042506 Mother Female 33 Year(s)	
Comments:	Neglect petition filed by BCDSS concerned the 3yo female SS following findings in the CPS investigation initiated 4/21/17. Concerns were for IF/C/S, IG, LS, and PD/AM, in addition to extensive indicated CPS history involving the 3yo child and prior siblings. Information was provided regarding multiple positive drug and alcohol screens for SM throughout her pregnancy with twins (included SC). SM and SF had refused to cooperate with BCDSS and BCDSS sought court intervention to protect the SS and address the concerns. SM and SF entered general denial and the matter was rescheduled for pre-trial conference. On 7/3/17 it was ordered that: BCDSS was to have supervision over SM, SF and the 3yo SS; the SS was not to be left unsupervised with SM, and the SF was to supervise all contact between SS and SF. A temporary order of supervision was put into place.	

Additional Local District Comments

BCDSS agrees with SY-17-039 report findings that BCDSS completed a thorough investigation and sufficiently responded to evolving circumstances. BCDSS believes it did a good quality fatality investigation and documented it. Broome County does not have a MDT. In regard to the citations made concerning historical CPS investigations done by BCDSS, none of the citations if done correctly would have resulted in this child surviving and had nothing to do with the death of this child. Many of the citations on various issues including the Risk Assessment Protocol (RAP) have been self-identified by

Broome during past Ongoing and Monitoring Assessments (OMA) and are a part of Broome's work with the Regional Office of Family and Children Services. Broome will work with our Regional Office to incorporate the Performance Improvement Plan with activities already in place.

Broome recommends that OCFS review the RAP instrument as many seasoned supervisors have difficulty completing it and doing so accurately. The RAP present numerous challenges to already stressed and overwhelmed work force. Also, Broome recommends that fatality reports focus on the primary purpose of preventing similar fatalities from occurring in the future and leave the auditing of historical CPS investigations to Ongoing Monitoring & Assessment that occurs regularly at the district. The inclusion of the historical CPS investigation issues takes away from the fatality reports and gives the impression that these citations are related to the fatality itself.

Recommended Action(s)

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

Action:	In the Preventive Services case from June 2008 to October 2008, there was no documentation of any services being provided. There were no progress notes or FASPs completed, though the intake note stated services were needed in order to prevent placement. Just prior to the closing of this case and the opening of another, the CHN did end up being removed. While the next services case was open, the tracking of the CHN's permanency planning goals and movement regarding types of custody were not accurately recorded thus causing inconsistencies in pertinent documentation. This tracking issue was prevalent in the current Ongoing Services case upon removal of additional CHN, resulting in information failing to be captured regarding the CHN's Foster Care information within the FASP. OCFS recommends BCDSS review their practice and documentation in Preventive and Ongoing Services cases and continue working on any program improvement plans that may currently be in place to address these issues.

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