Child Fatality Report

Report Identification Number: RO-20-022

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

Issue Date: Mar 04, 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: 6 year(s)
Jurisdiction: Steuben
Gender: Female
Date of Death: 09/14/2020
Initial Date OCFS Notified: 09/16/2020

Presenting Information

Steuben County Department of Social Services (SCDSS) received an SCR report that stated on 9/14/20, the father was driving while impaired with the subject child in the vehicle.The father lost control of the vehicle and hit a guardrail, the vehicle then flipped over landing on the driver's side and hit a telephone pole. The subject child was sitting in the back seat of the car and was crushed when the vehicle hit the telephone pole. Law enforcement and EMS responded to the scene. The subject child was declared deceased at the scene of the accident and was taken for an autopsy. The autopsy determined the child sustained a skull fracture and massive trauma to her entire body. The father admitted to methamphetamine and heroin use. The father was charged with manslaughter in the second degree and was incarcerated. It was unknown if the mother or grandmother were aware the father was driving while impaired.

Executive Summary

On 9/16/20, SCDSS received the SCR report regarding the death of the 6-year-old subject child. At the time of her death, the SC resided with the SF, PGM, a PA and the PGM's fiancé. The SC's BM did not reside in the home, but had visitation. The SF had an open CPS investigation at the time of the fatality concerning his supervision of the SC. There were no surviving siblings or other children in the household.

SCDSS completed casework and collateral contacts and learned that on the day of the fatal accident, the SC attended school. At the end of the school day, the bus attempted to drop the SC off at her designated stop, which was at the end of the road the family lived on. No one was present to retrieve the SC and the bus brought her back to school. The SF asked the BM to pick up the SC from school. The school confirmed with the SF via telephone that the BM was able to pick up the SC, as it was their understanding the SC's contact with the BM required supervision. The SF gave permission for the SC to leave school with the BM and the BM and SC met the father and the SF took the SC home. On the way home, the SF reported he had swerved to avoid hitting an animal. The car hit the guard rail, a road sign and then a telephone pole, which fell onto the car and crushed it. The SF was able to get out of the vehicle; however, the SC was pinned inside. Upon arrival to the scene, first responders found a faint pulse for the SC utilizing a pulse probe. Efforts were made to extract the SC from the vehicle; however, due to the condition of the vehicle, it took two hours to get her out. The Coroner arrived to the scene prior to the extraction and declared the SC deceased at 7:15PM.

An autopsy was completed and revealed that the SC's preliminary cause of death was head injuries and multiple traumas. The SF reported to law enforcement that he had used heroin prior to the accident and first responders stated the SF appeared impaired upon their response to the scene. LE found there to be criminality related to the fatal incident, and charged the SF with vehicular manslaughter and murder in the second degree. The SF's toxicology report had not yet been received by LE or SCDSS. The SF was incarcerated and indicted on the charges by a grand jury.

It was discovered during the historical case review that in past the SC had been in direct relative placement with the MA under Article 1017 due to the SF and BM's substance use. The SC returned to the BM's care after she completed court ordered services in January 2019 and the SF, BM and a MA shared joint Article 6 custody of the SC, with the SF having supervised contact. In September 2019, the MA filed for sole custody of the SC after she had concerns with the parents' sobriety. The MA was awarded sole Article 6 custody and the parents were given supervised visitation through Livingston County Family Court. On 1/2/20, the SF was given sole custody of the SC and the BM was required to have supervised visits. The MA was contacted following the death and reported no known concerns for the SF's drug use.

In the initial open CPS investigation SCDSS completed safety assessments including questions about drug and alcohol use in the home. Initially, the household members reported no concern of drug use by the SF. Approximately a week after the initial SCR report, a family member reported concerns regarding the SF's substance use to SCDSS. The record did not reflect that the concerns were addressed with SC or SF.

SCDSS offered the BM, SF, PGM, PGM's fiancé and the two paternal aunts grief counseling and MH services. The allegations had not been determined and the CPS investigation remained open at the time this report was written.

PIP Requirement
OCFS' review resulted in citations. In response, each cited county will submit a Program Improvement Plan (PIP) to the Regional Office which will identify what action(s) the respective LDSS' have taken, or will take, to address the cited issues. For citations where a PIP is currently implemented, the respective LDSS 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The CPS investigation remained open at the time this report was written.

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

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

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

Explain:
There was documentation of detailed supervisory consultation in the case record. The CPS investigation had not yet been determined at the time this report was written.

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: 09/14/2020 **Time of Death:** 07:15 PM

Time of fatal incident, if different than time of death: 06:30 PM

County where fatality incident occurred: Steuben
Was 911 or local emergency number called? Yes
Time of Call: 06:30 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☒ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was:

- ☒ 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	Aunt/Uncle	No Role	Female	35 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	6 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	55 Year(s)
Deceased Child's Household	Other Adult - Grandmother's fiance	No Role	Male	62 Year(s)
Other Household 1	Mother	No Role	Female	26 Year(s)

LDSS Response

On 9/16/20, SCDSS received an SCR report regarding the death of the SC that occurred on 9/14/20. Within 24 hours of receipt of the SCR report SCDSS spoke to the source, completed a CPS history check, spoke to LE and notified the district attorney's office.

SCDSS interviewed the SF via telephone due to his incarceration and he reported the day of the accident he dropped the SC off at school and went to the junkyard to get a part for his car. He was not done in time to pick up the child from school, so he sent the BM to get the SC. The SF reported he had primary residential and legal custody of the SC and that he had discretion regarding the BM's contact with the SC. The BM brought the SC to the junk yard and the SF left the junk yard with the SC. While driving home, the SF swerved to avoid an animal and hit the guardrails. When SCDSS questioned the SF about current or past substance use, he declined to comment and advised SCDSS they could speak to his attorney.

SCDSS was notified of the fatal car accident by LE and was provided information regarding the SF's statements. LE and the District Attorney reported the SF admitted he used heroin prior to the accident. The SF reported to LE that while driving home with the SC he had swerved for a kitten; however, the District Attorney reported there were no signs of a swerve trajectory. The SF was traveling at approximately 50 miles per hour or greater when he hit the guardrail and the car tipped onto it's side, hit a road sign and then a telephone pole, which fell and crushed the roof of the car. SCDSS documented several efforts to conduct face-to-face and phone interviews with the BM; however, she was not cooperative. The BM blamed the SF for the death of the SC but declined to provide any additional information to SCDSS.

SCDSS gathered information from numerous first responders. The 911 call was made around 6:30PM by an off duty first responder who arrived after driving by the scene of the accident. The first responder observed the SF get out of the vehicle by himself; however, the SC was pinned inside and barely visible. EMS utilized a pulse probe and determined the SC had a faint pulse. First responders made several efforts to extract the SC from the vehicle. The Coroner arrived to the scene and declared the SC deceased at 7:15PM. After two hours, the SC was extracted from the vehicle and transported to the ME's office. First responders reported the SF appeared emotional, as he was screaming and trying to get the SC out of the car. They also reported the SF appeared under the influence and refused to have blood drawn by medical services. The BM was at the hospital following the accident, and LE reported she appeared impaired during their interview of her. LE obtained a warrant for the SF's home and discovered drugs, drug paraphernalia and weapons in his bedroom.

SCDSS interviewed relatives, including a PA, PGM, and the PGM's fiancé, who had consistent contact with the SF and SC. Previous to the fatality, the relatives expressed concern for the SF's substance abuse. There were video cameras in the home and the relatives saw the SF with drugs while the child was present. They also reported there had been changes to his demeanor. The PGM stated that she was going to file for guardianship of the SC, but the SF threatened to leave with the SC if she pursued family court action. The PA reported on the day of the fatality she had contacted the school to inform them of the supervised contact between the BM and SC. In addition, the PA reported she had seen the BM earlier in the day, and expressed concern to school personnel that the BM was impaired and the PA requested they not release the SC to the BM. School personnel was interviewed and reported the BF had given permission via telephone for the BM to pick up the SC and the BM did not appear impaired when they released the SC to her care.

Official Manner and Cause of Death

Official Manner: Pending
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?No
Comments: Steuben County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056303 - Deceased Child, Female, 6 Yrs	056349 - Father, Male, 30 Year(s)	DOA / Fatality	Pending
056303 - Deceased Child, Female, 6 Yrs	056349 - Father, Male, 30 Year(s)	Inadequate Guardianship	Pending
056303 - Deceased Child, Female, 6 Yrs	056349 - Father, Male, 30 Year(s)	Parents Drug / Alcohol Misuse	Pending

CPS Fatality Casework/Investigative Activities

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

Additional information:

The SF was incarcerated following the fatality. SCDSS documented efforts to interview the SF face-to-face; however, they were declined entry into the jail due to COVID-19. In addition, the SF and BM refused to be interviewed by CPS.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Vehicular manslaughter	**Degree:** 2		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
09/14/2020	Father	Pending	Had not yet occurred
Comments:	The father admitted to the use of drugs prior to the car accident that caused the death of the subject child.		

Criminal Charge: Murder	**Degree:** 2		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
12/30/2020	Father	Pending	Had not yet occurred
Comments:	The father admitted to the use of drugs prior to the car accident that caused the death of the subject child.		

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

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

Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother, father, grandmother, aunts and grandmother's fiancé were offered grief counseling and mental health counseling following the fatality.

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? Yes
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

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)
08/31/2020	Deceased Child, Female, 6 Years	Father, Male, 30 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 6 Years	Father, Male, 30 Years	Lack of Supervision	Substantiated	
	Deceased Child, Female, 6 Years	Father, Male, 30 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 6 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
SCDSS received an SCR report that stated on 8/30/20, the father took the subject child to the local park for a birthday party. The father went fishing and left the subject child to wander off to the playground. The father could not see the child from where he was fishing and did not check on her. The child was filthy and had suspicious scratches on her neck. The parents were physically abusive to the child. On an unknown date the father shoved the child's head into a wall and the mother picked her up and dropped her.

Report Determination: Indicated | **Date of Determination:** 12/09/2020

Basis for Determination:
The initial report contained allegations of IG and LS against the father. SCDSS found there to be some credible evidence to substantiate these allegations after completing casework and collateral contacts. It was reported that the father would leave the child unsupervised for periods of time. The allegation of PD/AM was added and substantiated against the father after the subject child died in a fatal car accident and the father admitted to the use of heroin prior to driving. The allegation against the BM was unsubstantiated. The SC made no disclosures and the BM refused to be interviewed.

OCFS Review Results:
SCDSS assessed the safety of the subject child within 24 hours of receipt of the SCR report. The history check, notification letters and assessment tools were completed within required time frames. There were efforts documented to complete all required face-to-face interviews. Notes were not entered contemporaneously with their event date and the record did not reflect notification of indication letters were provided. Although provided with information from a collateral contact that the father was using drugs, the record did not reflect the concern was addressed with the father or the subject child.

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

Issue:
Failure to Provide Notice of Indication
Summary:
The notice of indication letters were provided outside of regulatory timeframes.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
If SCDSS determines, within 60 days, a report assigned to the investigative track is "indicated" they must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
On 9/8/20, SCDSS was provided with information from a collateral contact that the father was using drugs and the record did not reflect contact was made with the subject child and father to address the concerns.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. SCDSS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Approximately 12 progress notes were entered more than a month after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/15/2020	Other Child - Cousin , Male, 15 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
SCDSS received an SCR report that alleged on several occasions the father took the 15yo cousin to burglarize abandoned homes. The father took the cousin to another county to commit petit larceny and tried to force the cousin to commit the crimes with him. The roles of the aunt and grandmother were unknown.

Report Determination: Indicated | **Date of Determination:** 07/10/2020

Basis for Determination:
SCDSS determined the father brought the cousin to an abandoned home to burglarize it. The father denied this to be true, but law enforcement had criminally charged the father for endangering the welfare of a child and property related offenses.

OCFS Review Results:
SCDSS assessed the safety of the subject child within 24 hours of receipt of the SCR report. Notes were entered contemporaneously with their event date and notification letters were provided timely. SCDSS received additional concerns regarding the BF's drug use during the investigation and thoroughly investigated them. SCDSS documented several home visits and collateral contacts.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/09/2019	Deceased Child, Female, 5 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 5 Years	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 5 Years	Unrelated Home Member, Male, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 5 Years	Unrelated Home Member, Male, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 5 Years	Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

Report Summary:
SCDSS received an SCR report that alleged the mother had a history of abusing drugs while caring for the subject child. Because of the mother's drug use, she failed to provide food for the SC for several days. The unrelated home members also abused methamphetamine while caring for the subject child. On 9/8/18, at approximately 5:00PM, the mother was high on methamphetamine and physically assaulted another adult while the subject child was present. The father had an unknown role.

Report Determination: Unfounded | **Date of Determination:** 11/22/2019

Basis for Determination:
SCDSS requested law enforcement conduct a welfare check on the subject child and at that time the mother was found to be a sober care giver. During home visits, there were no concerns for substance abuse, the amount of food in the home or drug paraphernalia accessible to the child. The mother submitted to a drug screen and was negative for all substances. The subject child denied any knowledge of drug use.

OCFS Review Results:
SCDSS assessed the safety of the subject child within 24 hours of receipt of the SCR report. There was supervisory consultation documented throughout the investigation. Notes were entered contemporaneously with their event date and notification letters were provided timely. SCDSS documented several collateral contacts. Not all required face-to-face contact was documented.

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

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

Summary:
Although the father was spoken to on the phone, the record did not reflect he was interviewed face-to-face or that there was a visit to his residence where he had visits with the subject child.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
SCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/09/2018	Deceased Child, Female, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 3 Years	Father, Male, 27 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 3 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
Livingston County Department of Social Services (LCDSS) received an SCR report that alleged the mother abused Subutex to the point of impairment while acting as the sole caregiver for the subject child. The father had an unknown role.

Report Determination: Indicated | **Date of Determination:** 03/20/2018

Basis for Determination:
LCDSS determined there was some credible evidence to substantiate the allegations against the BM. LCDSS determined the BM was hospitalized due to an infection related to intravenous drug use and this caused a major disruption in the SC's life. LCDSS added an allegation of IG against the SF and found there to be some credible evidence to substantiate it. The SF was required to have supervised visitation with the SC and was required to take drugs screen prior to visitation. It was determined through interviews with the SC and BM that the father was visiting with the SC without submitting to drugs screens. In addition, the BF had failed to engage in services to address his MH and substance use.

OCFS Review Results:
LCDSS assessed the safety of the subject child within 24 hours of receipt of the SCR report. LCDSS completed all required face-to-face contacts, conducted phone calls with collaterals and completed home visits. Notification letters were mailed timely. LCDSS appropriately determined the allegations given the information obtained during the investigation. The record did not reflect a history check was completed within 1 business day of receipt of the SCR report. The 7-day Safety Assessment was submitted and approved late in connections.

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 completed late in Connections on 1/19/18.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
LCDSS will document and approve all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.
PIP Requirement:
LCDSS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) LCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, LCDSS will review the plan and revise as needed to address ongoing concerns.

Issue:
Review of CPS History
Summary:
It was not documented that a CPS history check was completed within 1 business day of receipt of the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within one business day, LCDSS will review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded reports where the current report involves a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report. The history check should be documented in progress notes accordingly.
PIP Requirement:
LCDSS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) LCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, LCDSS will review the plan and revise as needed to address ongoing concerns.

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

The mother and father had CPS history in Livingston County. In 2014, the mother had an unfounded CPS investigation with allegations of PD/AM regarding the subject child and the mother and father had an unfounded CPS investigation with allegations of IG and PD/AM regarding the subject child. In 2016, the father and his significant other at the time had an unfounded CPS investigation with allegations of IG and PD/AM regarding the subject child. In 2016, the mother and father had an indicated CPS investigation with allegations of IG and PD/AM regarding the subject child.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Preventive Services History

On 11/9/16, the SC was placed in the custody of the MA under Article 1017. Livingston County Department of Social Services (LCDSS) filed a Neglect petition against the BM and SF due to concerns of drug use and domestic violence in the home. The parents made admissions to neglect and were court ordered to engage in services, including domestic violence services, mental health counseling, parenting education and addictions counseling treatment. On 11/7/17, the SC returned

to the BM after she completed her services. The SF was required to continue supervised visitation and produce clean drug screens prior to visits. In January 2018, the BM relapsed and it was determined the SF was not abiding by his conditions for visitation with the SC. LCDSS removed the SC and she was placed in the custody of the MA under Article 1017. Another Neglect petition was filed on 3/1/18. The BM made admissions to neglect and the SF was found to be neglectful through a hearing. The parents were court ordered to re-engage in services. The BM completed her court ordered services and the SC was returned to her care on 1/18/19, with joint Article 6 custody between the BM, MA and SF. Upon the SC's return to the BM, the preventive services case was closed. At case closure, visits between the BF and SC were required to be supervised and the BF had to petition the court if he wanted changes to his visitation.

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: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/01/2018	Adjudicated Neglected	Order of Supervision
Respondent:	056349 Father Male 30 Year(s)	
Comments:	LCDSS filed a Neglect petition on 3/1/18 and the father was found to be neglectful through a hearing on 5/8/18. The father was court ordered to re-engage in services. The child returned to the mother on 1/18/19, with shared Article 6 custody between the mother, maternal aunt and father. The father was required to have supervised visits until he completed his order of supervision.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/01/2018	Adjudicated Neglected	Order of Supervision
Respondent:	056353 Mother Female 26 Year(s)	
Comments:	LCDSS filed a Neglect petition on 3/1/18 and the mother made admissions to neglect on 4/6/18. The mother was court ordered to re-engage in services. The child returned to the mother on 1/18/19, with shared Article 6 custody between the mother, maternal aunt and father.	

Have any Orders of Protection been issued? Yes	
From: 01/01/2018	**To:** Unknown
Explain: After the child was placed in the custody of the maternal aunt under Article 1017 in January 2018, there was an order of protection between the parents and the child, which required supervised contact. The mother was awarded custody on 1/18/19, and the father continued to have supervised visits. In September 2019, the maternal aunt filed for primary residential custody after she had concerns about the parents' sobriety. As a result, the parents were required to have supervised contact with the subject child. On 1/2/20, the father was awarded primary legal and residential custody and the mother was required to continue supervised visitation. All of above court appearances occurred in Livingston County Court.	

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