Child Fatality Report

Report Identification Number: RO-21-019

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

Issue Date: Jan 31, 2022

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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Livingston
Gender: Male
Date of Death: 08/23/2021
Initial Date OCFS Notified: 08/23/2021

Presenting Information

An SCR report alleged that on 8/23/21, at approximately 8:30AM, the mother went to sleep on the couch with the subject child in her arms. While sleeping, the mother rolled over on her side and the child slipped under her chest. At approximately 1:30PM, the aunt found the mother asleep and the child under the mother's breasts. The child was not breathing, had no pulse and his lips were blue. The uncle called 911 immediately. Emergency medical services performed cardiopulmonary resuscitation but the child was pronounced dead at the scene from apparent suffocation.

Executive Summary

On 8/23/21, the Livingston County Department of Social Services (LCDSS) received an SCR report regarding the death of the 5-month-old male child that occurred on the same day. At the time of the child's death, he resided with his mother, 6-year-old sibling and maternal grandfather. The mother had a 3-year-old, who resided with her paternal grandmother and visited with the mother. The siblings were assessed to be safe in the care of their grandparents.

LCDSS conducted a joint investigation with law enforcement to gather information regarding the fatality. It was learned on 8/22/21, the mother and child went to the aunt's house to spend time with family. Also present at the aunt's home was the aunt's boyfriend and two unrelated adults. The adults reported the mother tended to the child throughout the day and there were no concerns. In the evening, the mother and child went to sleep on the aunt's couch. The aunt had left the home for an overnight work shift and returned on the morning of 8/23/21. Upon the aunt's return, the mother woke and fed the child and went back to sleep. The aunt woke several hours later and went downstairs to find the mother sleeping on top of the child. The child was unresponsive. The aunt's boyfriend called 911 and emergency medical services responded. The child was declared deceased at the residence and transported to the Medical Examiner's office.

An autopsy was performed and the preliminary results did not show any indicators of physical abuse or maltreatment. The official cause and manner of death were pending the toxicology report. At the time the report was written, there had been no criminal charges filed related to the child's death, and law enforcement's investigation was pending.

LCDSS had not yet determined the allegations at the time this report was written. LCDSS offered the parents, grandparents, other adults and sibling mental health and grief counseling services. The 6-year-old sibling was enrolled in mental health counseling as a result of the fatality.

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.

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?** Yes

Determination:

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

Explain:
The allegations had not yet been determined at the time this report was written and the CPS investigation remained open.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
Although LCDSS documented an assessment of the siblings' safety throughout the investigation, they did not complete the corresponding 7-day and 30-day safety assessment tools in Connections. In addition, the 24-hour and 30-day fatality reports were completed late.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	Although LCDSS assessed for safety within 30-days of receipt of the investigation, the 30-day safety assessment was not completed in Connections.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	LCDSS must complete a safety assessment at 30 days for reports of a child fatality, unless there are no surviving siblings or children in the household. This is in addition to the 24-hour assessment, the seven-day assessment and the conclusion safety assessment.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	Although safety was assessed at 30-days through casework and collateral contacts, LCDSS submitted and approved the 30-day fatality report late in Connections on 10/1/21.
Legal Reference:	CPS Program Manual, Chapter 6, K-2

Action:	The 30-day Fatality Report must be documented in a template in Connections within 30 days of the receipt of a report alleging the death of a child because of abuse or maltreatment.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 7-day safety assessment tool was not completed in Connections.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	LCDSS will document and approve all safety assessments within the required time frame.
Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-hour fatality report was completed late in Connections on 8/25/21.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	LCDSS must document and approve a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/23/2021 **Time of Death:** Unknown

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

County where fatality incident occurred: Livingston
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 6 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	5 Month(s)
Deceased Child's Household	Grandparent	No Role	Male	64 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Other Household 1	Father	No Role	Male	33 Year(s)
Other Household 2	Other Adult - Father of 6yo sibling	No Role	Male	31 Year(s)
Other Household 3	Sibling	No Role	Female	3 Year(s)
Other Household 4	Other Adult - Father of the 3-year-old sibling	No Role	Male	25 Year(s)

LDSS Response

Upon receipt of the SCR report on 8/23/21, LCDSS initiated their investigation and coordinated efforts with law enforcement, conducted a CPS history check and spoke to the source. The safety of the 6-year-old and 3-year-old siblings was assessed, and it was determined they were safe in the care of their grandparents.

LCDSS interviewed the mother and learned that on 8/22/21, the mother and child went to the aunt's house to spend the night. Also at the home was the aunt, her boyfriend, and two unrelated adults. The mother stated during the day the child had a bottle of apple juice and baby food, and in the evening, she had given him formula. It was a typical day for the child and nothing was out of the ordinary. The mother stated there were no concerns for the child when they went to sleep on the couch. The child slept at one end of the couch near the mother's feet. On 8/23/21, at approximately 7:00AM, the mother fed the child a bottle and the aunt was returning home from an overnight work shift. The mother next remembered being woken up by the aunt around 1:00PM, who was holding the child and saying he was not breathing. The mother performed CPR and the aunt's boyfriend called 911. The mother denied the child had any pre-existing medical conditions. The child was pronounced deceased at the residence and transported to the Medical Examiner's office.

The aunt reported that on 8/22/21 at 10:50PM, she had left her home for her overnight shift and returned on 8/23/21 at 7:10AM. When she arrived home, everyone was asleep, and she heard the child whining. The mother woke and gave the child apple juice and baby food. The aunt reported it was typical for the mother to co-sleep with the child, and the aunt had previously warned the mother about the dangers of this. The aunt also stated the mother was a heavy sleeper and could sleep through the child crying. The aunt went to sleep and awoke around 1:00PM. The mother was asleep on the couch. The aunt went over to the mother and saw that she was asleep on top of the child and pulled her off of him.

The father was incarcerated in Chautauqua County. Chautauqua County Department of Social Services completed a face-to-face interview and discussed services with the father at the request of LCDSS. The father was informed by the mother the child had died of SIDS. He expressed no concern for the mother's care of the child. The 6-year-old sibling was in joint custody of the mother and maternal grandfather, and was primarily cared for by the grandfather. The 3-year-old sibling was in joint custody of the mother, the sibling's father and paternal grandmother. The 3-year-old resided with the grandmother and the mother's visits were supervised. The siblings were in shared custody due to the mother's history of substance misuse. The siblings were not present when the fatality occurred. The grandfather reported that he shared care taking responsibilities of the child with the mother. The grandfather would place the child to sleep in a basinet, but the mother would sometimes sleep in bed with him. The grandfather stated the mother was a heavy sleeper, and if the child woke in the night, he would typically be the one to tend to him. The grandfather reported he had spoken to the mother about the dangers of co-sleeping.

The unrelated adults were interviewed and their account of events were consistent with each others. The adults stated they went to sleep on 8/23/21 around 1:00AM. They were woken by the aunt screaming around 1:00PM. They had no concerns for the mother's care of the child the night leading up to the fatality. The adults reported there was some alcohol and marijuana use that had occurred; however, the mother did not partake in it and was not impaired. There were concerns about the mother's misuse of her prescription medication, due to her behaviors, including extreme drowsiness or inability to sleep. The grandfather reported he would care for the children if the mother was not able.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: Livingston County Department of Social Services does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058854 - Deceased Child, Male, 5 Month(s)	058855 - Mother, Female, 32 Year(s)	DOA / Fatality	Pending
058854 - Deceased Child, Male, 5 Month(s)	058855 - Mother, Female, 32 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?	☒	☐	☐	☐

Additional information:
LCDSS documented efforts to locate absent parents and interview them face-to-face.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine

Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

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

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The parents and caretakers of the siblings were provided information on counseling services on behalf of the siblings. The 6-year-old was enrolled in mental health counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents, grandparents and other adults present at the time of the death were offered mental health counseling and grief counseling.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☒ Used illicit drugs

Infant was born:

- ☒ Drug exposed
- ☐ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/14/2021	Other Child - Unrelated , Female, 8 Years	Other Adult - Grandmother of the 3-year-old sibling, Female, 47 Years	Excessive Corporal Punishment	Unsubstantiated	No
	Sibling, Female, 3 Years	Other Adult - Grandmother of the 3-year-old sibling, Female, 47 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unrelated , Female, 8 Years	Other Adult - Grandmother of the 3-year-old sibling, Female, 47 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unrelated , Female, 5 Years	Other Adult - Grandmother of the 3-year-old sibling, Female, 47 Years	Inadequate Guardianship	Unsubstantiated	

Other Child - Unrelated , Female, 13 Years	Other Adult - Grandmother of the 3-year-old sibling, Female, 47 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 3 Years	Other Adult - Unrelated , Male, 53 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Unrelated , Female, 8 Years	Other Adult - Unrelated , Male, 53 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Unrelated , Female, 5 Years	Other Adult - Unrelated , Male, 53 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Unrelated , Female, 13 Years	Other Adult - Unrelated , Male, 53 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report alleged that the paternal grandmother of the 3yo sibling and her partner had cameras inside and outside of the house, including several in the bathroom. It further stated that they were watching the 3yo sibling and 15yo, 14yo, 8yo and 5yo unrelated children when they took baths, showers and used the toilet. The children were aware of the cameras and were uncomfortable. The unrelated 8yo child would urinate in the bed at night, and the 3yo sibling's paternal grandmother physically beat her as a result. Sometime in March 2021, the 3yo sibling's paternal grandmother was angry with the 8yo, so she placed her hand on a hot stove top burner.

Report Determination: Unfounded | **Date of Determination:** 09/02/2021

Basis for Determination:
LCDSS interviewed the 3yo's PGM, her partner and the CHN and found there was lack of credible evidence to substantiate the allegations. The CHN were aware of the cameras; however, reported they were used to monitor the unrelated 8yo's behaviors. The CHN denied the cameras made them uncomfortable. The PGM was working with community services regarding the behaviors. The PGM reported the bathroom camera was only used when the 8yo was in there, to monitor her behaviors. There were concerns about discipline of the 8yo being excessive, which were addressed with the PGM. The 8yo had no visible injuries from the alleged burning incident and did not disclose being burnt when asked about discipline.

OCFS Review Results:
LCDSS made home visits and completed required face-to-face contacts. Efforts were documented to obtain contact information for absent parents and complete interviews. Notification letters were provided to all required adults. LCDSS gathered information from several collateral contacts, including the pediatrician, family friends, and service providers. Concerns were addressed with the SS's PGM and service referrals were made as necessary. The SS's PGM would not allow LCDSS to interview the CHN without her present. LCDSS did not document specifically asking the 8yo about the burning incident; however, they were extensive in their efforts to gather information about discipline in the home.

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)
03/07/2021	Deceased Child, Male, 1 Days	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:
An SCR report alleged that the mother used marijuana and the child subject child tested positive for marijuana at the time of his birth.

Report Determination: Unfounded	**Date of Determination:** 05/20/2021

Basis for Determination:
LCDSS unfounded for the allegations of Parent's Drug/Alcohol Misuse against the mother regarding the subject child. LCDSS completed casework and collateral contacts. The mother and father admitted to marijuana use; however, reported they did this in the basement of the home. The grandfather was in the home and denied substance misuse. The subject child's discharge paperwork from the hospital indicated that he had no signs of withdrawal syndrome. LCDSS followed up with the child's doctor, and he continued to show no signs of concern in the weeks after his birth.

OCFS Review Results:
LCDSS made an appropriate determination given the information obtained during the investigation. LCDSS made home visits, spoke to the source, completed required assessments timely and accurately and completed required face-to-face contacts. Notification letters were provided to all required adults. The record did not reflect that a Plan of Safe Care was completed with the mother. In addition, the child's sleep arrangements were not documented as being observed and it was not documented that safe sleep guidance was provided.

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

Issue:
Failure to provide safe sleep education/information

Summary:
Although a supervisory case conference at case closure indicated that the child's sleeping arrangements were observed and safe sleep guidance was provided, this was not documented during contacts with the family.

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

Action:
13-OCFS-ADM-02 notes a review and assessment of a child's sleeping environment must be documented, and immediately addressed if assessed to be unsafe. In all CPS investigations with an infant in the home, caregivers must be provided with safe sleep information.

Issue:
Failure to complete, document, and monitor a Plan of Safe Care

Summary:
Although LCDSS addressed the allegation of marijuana misuse with the mother and offered substance misuse services, the record did not reflect that a Plan of Safe Care was completed.

Legal Reference:
17-OCFS-LCM-03 & 18-OCFS-LCM-06

Action:
LCDSS will complete, document & monitor a plan of safe care that specifically addresses the child(ren) affected by substance abuse and the affected caregiver. LCDSS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/22/2020	Sibling, Female, 5 Years	Grandparent, Male, 62 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Female, 5 Years	Grandparent, Male, 62 Years	Lack of Supervision	Substantiated	

Report Summary:
An SCR report alleged that on 04/14/20, the grandfather did not make an adequate plan of care for the now 6yo sibling. The grandfather left the sibling unsupervised in the home during the evening hours to move a vehicle. The sibling was not mature enough to be left unsupervised for any length of time. The mother and the father had unknown roles.

Report Determination: Indicated	**Date of Determination:** 05/20/2020

Basis for Determination:
LCDSS determined there was credible evidence to substantiate the allegations against the grandfather. LCDSS stated that the grandfather left the sibling home alone during the night for approximately eighteen minutes. Although the sibling was not aware she was alone, LCDSS found the grandfather failed to exercise a minimum degree of care in providing appropriate guardianship and supervision to the sibling and that his failure to do so placed her at risk of physical, mental and emotional harm.

OCFS Review Results:
LCDSS made home visits, spoke to the source, completed a CPS history check and completed required face-to-face contacts. Efforts were documented to obtain contact information for absent parents and complete interviews with them. Notification letters were provided to all required adults. LCDSS gathered information from several collateral contacts, including the school and law enforcement. There was supervisory consultation documented throughout the investigation.

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)
11/24/2019	Sibling, Female, 4 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 4 Years	Aunt/Uncle, Female, 28 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report alleged on 11/24/19, at approximately 4:25PM, the mother and the aunt physically assaulted each other while in the presence of the now 6yo sibling. The mother and the aunt were fighting because the mother accused the aunt of being a bad mother. The aunt threw popcorn in the mother's face and mother punched the aunt in the face while in the direct presence of the sibling. While the aunt and the mother were in the basement, the mother pushed the aunt against a bookshelf and they both punched each other while the sibling was at the top of the stairs witnessing the altercation. The mother left the scene after the incident. The sibling sustained no physical injuries.

Report Determination: Indicated	**Date of Determination:** 03/23/2020

Basis for Determination:
LCDSS completed interviews with the aunt and sibling and determined there was credible evidence to substantiate the allegations against the mother and aunt. The aunt and mother were charged with endangering the welfare of a child regarding their physical altercation in the presence of the now 6yo sibling.

OCFS Review Results:
LCDSS made an appropriate determination given the information obtained during the investigation. LCDSS made home visits and completed required face-to-face contacts. Efforts were documented to obtain contact information for absent parents and complete required contacts. Notification letters were provided to all required adults. The 7-day safety assessment was completed late and did not accurately reflect case circumstances.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-day safety assessment was submitted and approved late on 12/3/19. In addition, there were safety factors present that were not accurately identified, including the SM's substance abuse and a domestic incident witnessed by the SS. The SSs were in joint custody with relatives, who were not allowing unsupervised contact with the SM due to these concerns.

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 decisions, parent/caretaker actions and safety plan that had been devised.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/02/2019	Sibling, Female, 3 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 3 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged that the mother misused marijuana to the point of impairment. As a result, she lacked parenting skills to care for now 3yo sibling and the grandparents raised the sibling since birth. When the sibling visited the mother, she failed to meet the sibling's needs. The mother left the sibling in dirty and wet diapers and would not bathe the her. The mother attended rehabilitation programs, but would leave prior to successful completion. At the time of the SCR report, the mother unsuccessfully left rehab and demanded to take the sibling from her paternal grandmother. The report alleged the sibling was not safe with the mother.

Report Determination: Unfounded | **Date of Determination:** 01/24/2020

Basis for Determination:
LCDSS unsubstantiated the allegations due to a lack of credible evidence. At the time of the determination, it was suspected that the mother was misusing drugs and was not engaged in treatment. The mother had some contact with the 3yo sibling, but there was no credible evidence to support that she had cared for her under the influence of drugs. The 3yo sibling had been cared for by her grandmother since she was an infant. The mother and the 3yo's grandmother had joint custody and the 3yo's grandmother intended to pursue sole custody. The 3yo's grandmother agreed to not allow visitation if the mother appeared impaired.

OCFS Review Results:
Upon receipt of the SCR report, LCDSS made face-to-face contact with the mother and now 3yo sibling at the mother's home. The mother did not appear under the influence at that time. The now 6yo sibling was asleep inside during the home visit and was not interviewed, nor was it documented her safety was assessed during the investigation. Not all required notice of existence letters were provided. Safety assessments and the RAP did not reflect information documented in the case record.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The risk was not accurately reflected due to the mother not being identified as a caretaker. The mother had contact with and a caretaking role for the 3yo during the investigation. In addition, the mother resided with the 6yo sibling and was responsible for her care.

Legal Reference:
18 NYCRR 432.2(d)

Action:
LCDSS 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:
Timely/Adequate Seven Day Assessment

Summary:

The 7-day safety assessment was completed late on 8/30/19. In addition, the safety assessment tool did not accurately reflect the information in the record. The mother's drug misuse and time in rehab, resulted in grandparents caring for the siblings, as she was unable to do so. In addition, the 3yo's grandmother was asked to not allow visits if the mother appeared impaired.

Legal Reference:

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

Action:

LCDSS will document and approve all assessments within required timeframes, and accurately reflect the safety factors that are present, along with any safety plan/parent caretaker action that has been devised.

Issue:

Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:

The record did not reflect that the 6yo sibling or grandfather were interviewed during the investigation.

Legal Reference:

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

Action:

LCDSS must complete face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Issue:

Failure to provide notice of report

Summary:

Although notice of existence was provided to some of the required adults, the record did not reflect the biological fathers of the siblings or the maternal grandfather, whom resided with the mother and 6yo sibling, were provided with notice of the SCR report.

Legal Reference:

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

Action:

LCDSS will mail or deliver notification letters to subject(s), parent(s), absent parents and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

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

The mother had three unfounded and two indicated CPS investigations between 2015 and 2017. Substantiated allegations included Inadequate Guardianship and were in relation to the 6-year-old sibling. Unsubstantiated allegations included Parent's Drug/Alcohol Misuse and were in relation to the 6-year-old and 3-year-old siblings.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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