Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-20-022

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

Issue Date: Aug 28, 2020

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: 3 month(s)
Jurisdiction: Oswego
Gender: Female
Date of Death: 05/26/2020
Initial Date OCFS Notified: 05/27/2020

Presenting Information

On 5/26/20, the death of the 3-month-old female child was reported to OCFS by Oswego County Department of Social Services (OCDSS) through the required 7065-Agency Reporting Form. The child died on 5/26/20, after she was provided with comfort care by her medical team staff due to birth defects.

Executive Summary

This fatality report concerns the death of a 3-month-old female child that occurred on 5/26/20. The child was listed on an open CPS case at the time of her death. The investigation began on 2/28/20, after an SCR report was received with concerns of the mother's substance abuse at the time of the subject child's birth. In addition, the family had an open Preventive Services case due to a neglect filed against the father and an Order of Supervision, which was being monitored by Oswego Count Department of Social Services (OCDSS). There was a 10-year-old surviving sibling who was assessed to be safe in the care of her parents.

OCDSS was notified of the fatality by the father and immediately gathered information related to the death. It was learned that the mother had received pre natal care and became aware of possible birth defects for the subject child. The subject child was diagnosed with congenital heart disease while in utero. The child was born after an emergency C-section and was intubated at birth. The child remained in the hospital from her birth until her death and during that time received various treatments and procedures in the intensive care unit. The plan for the child had been to receive heart surgery; however, the child's condition worsened and she was determined to not be a suitable candidate. The parents were counseled on the child's futile condition and on 5/26/20 decided to switch the child to comfort care. Comfort care was initiated and the child passed away on the same day with her parents present.

OCDSS made casework contact with the suriving sibling and paternal grandparents. The sibling stayed with the grandparents and the sibling's mother intermittently following the fatality, and was assessed to be safe in their care. Due to a history of substance abuse with the mother and father, an informal plan was made with the grandparents to keep the sibling in their care if the parents presented as under the influence of substances.

An abundance of services were offered following the fatality, including bereavement, mental health counseling and burial expense assistance. The family remained open with prevention services and community providers, who continued to assess the need for services following the fatality. OCDSS appropriately unfounded the allegations against the mother and closed the CPS case.

PIP Requirement

Oswego County Department of Social Services will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS 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:**
  - **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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
OCDSS adequately assessed for the safety and risk of the surviving sibling and the family was offered appropriate services.

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, signature or initials recorded (other than on FASP).

Explain:
OCDSS accurately assessed for safety and risk regarding the surviving sibling and discussed ongoing service needs with the prevention services caseworker. OCDSS determined there was no need for further CPS intervention and appropriately closed the case.

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: 05/26/2020 **Time of Death:** 06:56 PM

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

County where fatality incident occurred: Onondaga
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
- ☐ Playing
- ☒ Other: Hospitalized
- ☐ Working
- ☐ Eating
- ☐ Driving / Vehicle occupant
- ☐ Unknown

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Not impaired.

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	No Role	Female	3 Month(s)
Deceased Child's Household	Father	No Role	Male	24 Year(s)
Deceased Child's Household	Mother	No Role	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Other Household 1	Other Adult - Mother to 9-year-old sibling	No Role	Female	28 Year(s)

LDSS Response

Oswego County Department of Social Services had an open CPS investigation with the family at the time of the child fatality. The CPS case was opened on 2/28/20, after they received a SCR report with allegations of Inadequate Guardianship and Parent Drug Alcohol Misuse against the mother related to the subject child. In addition, the father, mother and sibling had an open Preventive Services case with a pending neglect and Order of Supervision against the father related to the sibling.

Oswego County Department of Social Services were made aware of the fatality on 5/27/20 and began obtaining records regarding the death. The subject child was born on 2/26/20 with significant medical issues that required hospitalization. The parents were aware of this possibility, as during prenatal care, the child was given a fetal diagnosis of congenital heart disease. The mother presented to the hospital for a C-section and the fetus was found to be bradycardia and an emergency C-section was performed. The child was blue at birth and not responding to oxygen and was intubated. The child was admitted to the NICU while continued medical care occurred. The plan for the child had been surgery and continued hospitalization; however, her condition continued to worsen and she was determined an unfit surgery candidate. The parents were counseled on alternative methods of care and ultimately decided to switch to comfort care. On the same day at 18:56, the child was pronounced deceased. An autopsy was requested; however, the parents declined. The child had multiple medical conditions that were thought to have contributed to her death.

OCDSS made several casework contacts from the initiation of the CPS investigation until it's closure. There were concerns presented to OCDSS by a secondary county regarding the father's substance abuse during their interview of the father. Further casework contacts determined that the father was sleep deprived and the parents did not appear under the influence of drugs during subsequent contacts. The father attended an addictions counseling evaluation after the fatality and was not recommended for treatment. A plan of safe care was completed with the parents and documented in Connections.

The surviving sibling was cared for by the paternal grandparents and the sibling's mother while the parents visited with the subject child and then made funeral arrangements. OCDSS assessed the sibling to be safe in their care. The grandparents

expressed no concern for their grandchild in the care of her parents. The sibling's mother expressed concern for the parent's substance abuse, which was addressed by OCDSS during the investigation and Preventive Services case.

OCDSS offered appropriate services throughout the case, including bereavement services and assistance with funeral expenses. The open Preventive Services case and community providers also coordinated services to the family following the fatality. The CPS investigation was unfounded and closed on 8/3/20 and the family remained open with prevention services.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
School	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☐	☒	☐
At 7 days?	☐	☐	☒	☐

At 30 days?	☐	☐	☒	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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?	☐	☐	☒	☐
Explain: As there was no SCR report surrounding the fatality, OCDSS inquired of relevant collaterals and family members as to whether there was reasonable cause to suspect abuse or maltreatment with respect to the SC's death. OCDSS found there to be no such reason. Although safety assessments in these instances are not required, OCDSS did assess and document the safety of the surviving sibling as part of this review.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: The RAP indicated that the father was enrolled in addictions counseling services; however, it was documented in the Preventive Services case that the father was not enrolled and had not yet attended an evaluation at the time the RAP was completed.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
There was no removal of any of the other children as they were not found to be in immediate or impending danger of serious harm.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
The parents were offered bereavement and burial assistance during the CPS investigation and were regularly assessed for needs in the prevention services case following the fatality. The sibling was provided with information on counseling; however, she reported she did not wish to enroll in the service at the time it was offered.

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:

OCDSS documented a discussion of services for the sibling; however, the sibling expressed she was not interested in engaging 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 were offered burial assistance and bereavement 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? Yes

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/28/2020	Deceased Child, Female, 2 Days	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 2 Days	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged the mother gave birth to the subject child on 2/26/20. At the time of the birth, the mother and child tested positive for opiates. The mother used heroin while pregnant with the subject child. The father and sibling had unknown roles.

Report Determination: Unfounded | **Date of Determination:** 08/03/2020

Basis for Determination:
OCDSS unsubstantiated the allegation of IG and PDRG against the mother. The mother admitted to drug use while

pregnant with the subject child. The information gathered related to the allegations does not show impact on the subject child; however, OCDSS did not complete a comprehensive narrative to reflect the information gathered in the investigation.

OCFS Review Results:
OCDSS conducted a thorough investigation and documented diligent efforts in obtaining information regarding the fatality. OCDSS assessed for safety within 24-hours of receipt of the SCR report and completed a plan of safe care. Appropriate services were offered to address concerns enumerated in the investigation and to support the family regarding the death of the SC. OCDSS did not document that a history check was completed until a month after receipt of the SCR report. The information gathered does not support safety factor 16 in the 7-day safety assessment tool, as it is not documented that the parents were unable or unwilling to provide care and protection for the SC's medical concerns.

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 inaccurately. OCDSS included safety factor 16 in the assessment; however, the information documented does not support that the parents were unwilling or unable to provide care and protection for the subject child's medical concerns. In addition, the subject child was born with a positive toxicology and this was not reflected.

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

Action:
OCDSS will document and approve all assessments and accurately reflect the safety factors that are present.

Issue:
Review of CPS History

Summary:
OCDSS completed a history check a month after the receipt of the SCR report.

Legal Reference:
18 NYCRR 432.2(b)(3)(i)

Action:
Within 1 business day of a report, OCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, ODSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/07/2017	Sibling, Female, 7 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Substantiated	Yes
	Aunt/Uncle, Male, 16 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Substantiated	
	Aunt/Uncle, Female, 15 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 7 Years	Grandparent, Male, 57 Years	Inadequate Guardianship	Substantiated	
	Aunt/Uncle, Male, 16 Years	Grandparent, Male, 57 Years	Inadequate Guardianship	Substantiated	

Aunt/Uncle, Female, 15 Years	Grandparent, Male, 57 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 7 Years	Father, Male, 22 Years	Inadequate Guardianship	Substantiated
Aunt/Uncle, Male, 16 Years	Father, Male, 22 Years	Inadequate Guardianship	Substantiated
Aunt/Uncle, Female, 15 Years	Father, Male, 22 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 7 Years	Father's Partner, Female, 22 Years	Inadequate Guardianship	Unsubstantiated
Aunt/Uncle, Male, 16 Years	Father's Partner, Female, 22 Years	Inadequate Guardianship	Unsubstantiated
Aunt/Uncle, Female, 15 Years	Father's Partner, Female, 22 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 7 Years	Father, Male, 22 Years	Parents Drug / Alcohol Misuse	Substantiated
Aunt/Uncle, Male, 16 Years	Father, Male, 22 Years	Parents Drug / Alcohol Misuse	Substantiated
Aunt/Uncle, Female, 15 Years	Father, Male, 22 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 7 Years	Father, Male, 22 Years	Lacerations / Bruises / Welts	Unsubstantiated

Report Summary:
An SCR report received alleged the grandparents had custody of the sibling. The father was not supposed to have contact with the sibling due to his substance abuse problem. Two months prior to the SCR report, the grandparents allowed the father and the father's partner to move into their home. The father continued to inject heroin in the presence of the sibling, as well as the then 15yo aunt and 16yo uncle. The grandparents and the father's partner were aware but failed to do anything to intervene. The father had syringes and needles in the home around the children. A week prior to the SCR report, the sibling was slapped in the face by the father, which left a welt and redness to her face

Report Determination: Indicated | **Date of Determination:** 12/21/2012

Basis for Determination:
OCDSS unsubstantiated the allegations against the father's partner as she was not identified as a caretaker to the children in the home.The allegation of LABW was unsubstantiated as there was no credible evidence that the sibling sustained redness or a welt due to her father slapping her. The allegation of IG was substantiated against the grandparents and the father because the then 16yo uncle required a higher level of supervision, which was not provided, putting the sibling and then 15yo aunt at risk of harm. The allegation of PDRG was substantiated due to the father being arrested for drug related crimes and using drugs while residing in the home.

OCFS Review Results:
OCDSS accurately assessed for safety within 24-hours of the SCR report. The notification letters were sent timely, multiple collaterals were contacted, home visits were conducted and concerns were addressed appropriately when they arose. OCDSS documented their CPS history check late and completed the 7-day safety assessment tool late in connections. It was not clearly documented how information to support safety factor 3 on the safety assessment was obtained and how the determination regarding PDRG against the father was supported.

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

Issue:
Review of CPS History

Summary:
The SCR report was received on 10/7/17; however, the history check was documented as completed on 10/16/17.

Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, OCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, OCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day safety assessment was completed and approved late in Connections. In addition, safety factor 3 was included in the assessment regarding drug misuse for the father; however, there was no documentation within the first 7 days of the investigation that supported this.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
OCDSS will document and approve all assessments and accurately reflect the safety factors that are present.

Issue:
Appropriateness of allegation determination
Summary:
OCDSS substantiated the allegation of PDRG against the father because of the father's arrest related to drug sales during the CPS investigation. OCDSS failed to correlate the father's drug use and/or sales to impact on the children and insufficient information was gathered to substantiate the allegation.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
OCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/08/2017	Sibling, Female, 7 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Substantiated	Yes
	Aunt/Uncle, Male, 16 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Substantiated	
	Aunt/Uncle, Female, 15 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 7 Years	Grandparent, Male, 57 Years	Inadequate Guardianship	Substantiated	
	Aunt/Uncle, Male, 16 Years	Grandparent, Male, 57 Years	Inadequate Guardianship	Substantiated	
	Aunt/Uncle, Female, 15 Years	Grandparent, Male, 57 Years	Inadequate Guardianship	Substantiated	
	Aunt/Uncle, Male, 16 Years	Grandparent, Female, 41 Years	Lack of Supervision	Substantiated	

Aunt/Uncle, Male, 16 Years	Grandparent, Male, 57 Years	Lack of Supervision	Substantiated
Sibling, Female, 7 Years	Grandparent, Female, 41 Years	Lack of Supervision	Unsubstantiated
Aunt/Uncle, Female, 15 Years	Grandparent, Female, 41 Years	Lack of Supervision	Unsubstantiated

Report Summary:
An SCR report alleged that the then 16yo uncle had a history of sexually offending against minors and required a higher level of supervision. The grandmother failed to provide the required supervision because she slept during the day, which left the uncle unsupervised with the then 15yo aunt and 7yo sibling. The role of the father was unknown.

Report Determination: Indicated **Date of Determination:** 12/21/2017

Basis for Determination:
OCDSS substantiated the allegations of IG and LSUP against the grandparents, as they determined there were multiple instances when the then 16yo uncle was not adequately supervised around the then 15yo aunt and then 7yo sibling, despite his need for a higher level of supervision. OCDSS filed a neglect against the grandparents related to these concerns and opened them to ongoing prevention services.

OCFS Review Results:
OCDSS contacted the source, made several home visits, documented a timely history check and adequately assessed for safety within 24 hours of the receipt of the SCR report. OCDSS appropriately addressed the allegations of the SCR report and additional concerns that arose during the investigation. In addition, OCDSS spoke to several collaterals and sent timely notification letters. During a casework contact, the primary caretaker identified mental health concerns for herself and this was not accurately reflected in the RAP. There was no documented contact with the family for a month during the investigation.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The grandmother identified having concerns with her mental health and this was not accurately reflected in the RAP.

Legal Reference:
18 NYCRR 432.2(d)

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

[redacted]

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

The FA had 2 UNF reports in 2016 with allegations of SA, IF/C/S, PD/AM and IG regarding the SS.

There are several reports regarding the SS and the sibling's MO. In 2010 the MO and PS had an IND report with sub allegations of IG and unsub allegations of FX, IF/C/S, LMC and S/D/S . In 2010 there was an IND report with sub allegations of IG and LMC against the MO, PS and grandparents and FX and L/B/W against the MO and PS. A neglect was filed and the SS was placed in foster care. In 2012 there was an UNF report against the MO with allegations of B/S, IG and L/B/W regarding the SS. In 2014 there were 3 CPS FAR cases with concerns of IG, LS and IF/C/S regarding the SS and the sibling's MO. In 2014 there was an UNF report with allegations of IG and L/B/W against the MO and IG and IF/C/S against the PS regarding an unrelated CH and SS. In 2014 there was an UNF report with allegations of IG against the MO and PS, FX against the PS and PD/AM against the OA regarding the SS and OCHN. In 2015 there were 3 IND

reports regarding the sibling. Sub allegations were IG and IF/C/S against the MO, OA and grandparents. Unsub allegations were PD/AM, L/B/W and IG against 2 other adults and the MO. In 2016 there were 3 IND reports related to the sibling. Sub allegations were IF/C/S, IG, LMC, XCP against the MO, PS and MGM and SA against a PS. Unsub allegations were IF/C/S, IG, II, PD/AM and LS. In 2017 there was an IND report with allegations of IG against the MO and PS and L/B/W against the PS.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 05/15/2018

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: 05/15/2018

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?	☒	☐	☐	☐

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?	☒	☐	☐	☐

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? The most recent FASP was due on 12/11/19 and was approved on 12/16/19.				
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?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐

Additional information, if necessary:
There was a Preventive Services case opened for the sibling's mother on 5/15/18 regarding an unrelated child. On 12/12/18, the father and sibling were added to the case. On 10/13/19 the mother was added to the case. The subject child had not been added to the case.

Required Action(s)

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

Issue:	Failure to Monitor
Summary:	There is no documentation in the case record that a CPS worker monitor was assigned to the case.
Legal Reference:	18 NYCRR 432.2(b)(5)
Action:	When CPS is not the primary service provider for a CPS case, the LDSS is responsible for monitoring the provision of services to children and families named in open indicated abuse and maltreatment reports.

Preventive Services History

From 9/29/15-8/31/16 the sibling's MO had an open Preventive Services case after a CPS investigation, which resulted in a neglect petition. The sibling's MO made admissions to neglect and was court ordered to complete services. The sibling's MO failed to complete those services and the FA was identified and given full custody of the sibling and the Preventive Services case closed.

From 12/12/16-11/27/18 the paternal grandparents had a Preventive Services case for behavioral concerns related to the PU. In January 2018, the sibling was added to the case after an informal placement with the grandparents due to concerns about the FA's substance abuse and criminal activity. The FA was added to the case on 2/24/18. On 9/6/18, the FA and MO to the sibling were ordered to engage in mental health services, substance abuse services and parenting classes. The grandparents continued custody of the sibling through a direct placement. In November 2018, the PU and grandparents completed services and the case closed. The MO of the sibling had an open Preventive Services case regarding an unrelated child. The sibling, FA and grandparents were added to her case and services were provided to work toward reunification of the sibling and her parents. The FA was given custody of the sibling on 7/25/19 with continued prevention services, which were open at the time of the fatality.

Foster Care Placement History

In October 2010, the sibling was placed in relative foster care because she sustained a spiral fracture while in the care of her mother and the sibling's alleged father. A neglect petition was filed against the sibling's mother and criminal charges were pursued against the mother and alleged father. The alleged father was identified by the mother as the sibling's father at that time; however, the father of the SC was identified as the sibling's father during the Preventive Services case via DNA testing. The sibling's mother and alleged father were court ordered services, including in home parenting education, individual counseling and couples counseling. In January 2012, the sibling was returned to her mother and alleged father by the judge against OCDSS objections. They continued prevention services until all court ordered services were completed and they requested case closure in September 2012.

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:**
12/20/2017	There was not a fact finding	Order of Supervision
Respondent:	054656 Father Male 24 Year(s)	
Comments:	On 12/20/17, OCDSS filed a neglect petition against the father in relation to the sibling because of concerns of substance abuse. After this, the father was incarcerated and during that time the sibling lived with the grandparents through an informal plan made by the father. On 9/6/18, custody of the sibling was given to the grandparents through an Article 10 Direct Placement and the father was court ordered to engage in services, monitored by OCDSS. The sibling returned to the father through a trial discharge on 4/30/19 and was final discharged to the father on 7/25/19 with the continuation of prevention services to monitor his Order of Supervision.	

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