Child Fatality Report

Report Identification Number: SY-21-014

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

Issue Date: Sep 03, 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: 4 day(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 02/27/2021
Initial Date OCFS Notified: 03/09/2021

Presenting Information

An agency reporting form was submitted which stated that on 2/23/21, the mother was pregnant with the child when she was found unresponsive by a relative. The child was delivered via C-section, and placed on a ventilator. The child remained unresponsive and was removed from life support on 2/27/21. He died on that same date. The child's mother never regained consciousness and died on 3/22/21. The child's death took place during an open CPS investigation.

Executive Summary

This fatality report concerns the death of a four-day-old male subject child that occurred on 2/27/21. The child died during an open CPS investigation that was initiated by Onondaga County Department of Social Services (OCDSS) on 2/23/21. The investigation was opened due to concerns the mother of the then unborn child had been found pregnant and unresponsive by a family member and there was no plan for her surviving children. An autopsy of the subject child was not completed per request of the family; however, a hospital physician noted the death was due to natural causes.

The child was delivered at 32.5 weeks gestation via C-section on the date the report was received, while the mother remained unconscious and on life support. Hospital staff noted a seizure and successive heart attack were most likely the cause of the mother's condition. The child was born unresponsive and placed on a ventilator in the Neonatal Intensive Care Unit. It was discovered the mother had a history of seizures, a heart condition, and abused alcohol daily throughout her pregnancy. The biological father of the subject child was unknown. The mother had two other children, a 12-year-old and a one-year-old. The 12-year-old had been in the care of the maternal grandmother prior to the mother's hospitalization; however, the one-year-old child was living with the mother in a motel room when the incident occurred. After the mother was hospitalized, the one-year-old child went to live with the maternal grandmother. Due to the mother's medical condition, the maternal grandmother was appointed health care proxy to both the mother and the subject child. On 2/27/21, the child's health was not improving, and the maternal grandmother made the decision to remove life saving interventions. The child survived independently for two hours before he was pronounced deceased. The mother was declared brain dead on 3/3/21 and died on 3/22/21.

When OCDSS learned of the child's death, they promptly assessed the safety of the surviving siblings and offered services to the family. It was determined there was no reasonable cause to suspect abuse or maltreatment led to the subject child's death, as he never left the hospital following his birth. OCDSS gathered sufficient information regarding the incident and were able to determine the allegations in the CPS investigation. The maternal grandmother was awarded custody of the surviving siblings via family court, and a services case was opened and ongoing at the time of this writing.

PIP Requirement
This review resulted in citations related to casework practice. In response, OCDSS will submit a PIP to their Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS will review the plan(s) and revise as needed.

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:
This was not an SCR reported fatality. Casework activity was commensurate with the case circumstances.

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:
This was not an SCR reported fatality; however, due to concerns that arose during the concurrent CPS investigation, the case was opened for mandated services.

Required Actions Related to the Fatality

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

Issue:	Child's death reported to the RO in a timely manner
Summary:	The subject child died on 2/27/21, and a completed OCFS 7065 Reporting Form was not submitted to the Regional Office until 3/9/21.
Legal Reference:	18 NYCRR 441.7(c)
Action:	OCDSS is required to provide telephone notice to the Regional Office within 24 hours of the learning of the death of a child in an open CPS or preventive services case. Within 72 hours of the death, OCDSS must complete a copy of the 7065 Form and e-mail or fax it to the Regional Office, and to any approved local or regional fatality review team that will review the fatality.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/27/2021 **Time of Death:** Unknown

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? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
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: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	4 Day(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Other Household 1	Grandparent	No Role	Female	51 Year(s)
Other Household 1	Sibling	No Role	Female	1 Year(s)
Other Household 1	Sibling	No Role	Male	12 Year(s)

LDSS Response

On 3/9/21, OCDSS submitted a completed agency reporting form to OCFS regarding the death of SC, which occurred on 2/27/21. OCDSS had been involved with the family since 2/23/21, after an SCR report was received with concerns SM had been found unresponsive by a relative in a motel room where SM and her 1yo CH had been staying. Shortly after being hospitalized, SC was delivered via emergency C-section while SM remained unresponsive. Both SM and SC were in critical condition and in intensive care units at the time the SCR report was made. It had been revealed SM had a history of excessive alcohol abuse, a seizure disorder, and a heart condition. OCDSS investigated the report allegations and concurrently gathered information surrounding the death of SC. OCDSS discovered SM's two CHN were in the care of MGM and worked promptly to assess their safety.

On 2/25/21, OCDSS spoke with hospital staff who explained SM had epilepsy, and it appeared that a seizure and heart attack led to SM's hospitalization. The staff reported SM had been drinking daily throughout her pregnancy, and it was likely SM's alcohol abuse led to the seizure; however, there was no way to know for certain. The hospital staff stated SM was still pregnant with SC at that time, and she and SC had gone at least 20 minutes without oxygen. SC was delivered at 32.5 weeks gestation, and neither SC nor SM were conscious as of the date of the report.

On 2/26/21, OCDSS spoke with MGM via phone. MGM explained that before she had both SSs in her care, SM and the 1yo SS had been living with the 1yo's BF; however, BF kicked them out of his house due to SM's drinking. MGM stated she did not have court ordered custody of either of the SS but planned to apply for such. MGM explained she had to make health care decisions surrounding SC since SM was not conscious, and removing SC's ventilator was being discussed with the hospital physician.

On 3/1/21, OCDSS was informed by hospital staff that SC died on 2/27/21 after being removed from a ventilator per MGM's decision. SC had "lived on his own" for two hours. The staff also explained there was no change to SM's condition, and on 3/3/21, hospital staff informed OCDSS that SM was declared brain dead.

On 3/4/21, OCDSS completed a visit to MGM's home to observe the environment and assess the safety of the SSs. OCDSS spoke with the 12yo SS, and there were no concerns noted.

On 3/24/21, MGM informed OCDSS that SM died on 3/22/21. OCDSS provided MGM with information on bereavement counseling services for herself and the SSs. On 3/25/21, both SSs were placed in the care and custody of MGM per family court. MGM declined an autopsy for SC. A hospital physician noted SC's death was due to natural causes. OCDSS gathered evidence to substantiate the allegations in the CPS investigation, and a services case was opened in response. Family Court proceedings regarding a neglect petition against BF and custody of the SSs remained ongoing at the time of this writing.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Onondaga County Child Fatality Review Team.

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?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

OCDSS interviewed family and collateral sources, including the 1yo SS's father's probation officer. Attempts to interview the 12yo's BF were unsuccessful. Progress notes and other documentation were completed within the required timeframes.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine

Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The surviving siblings did not need to be removed as a result of this fatality; however, their maternal grandmother petitioned for, and was awarded custody.				

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Court Ordered Services							

Additional information, if necessary:
OCDSS provided the grandmother and other family members with bereavement counseling referrals and information on assistance with funeral costs. A court ordered services case was opened in response to concerns that arose during the open CPS investigation and remained ongoing at the time of this writing.

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 provided the family with referrals for grief and bereavement counseling services for the siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS provided the family with referrals for grief and bereavement counseling services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
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?	No
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)
02/25/2021	Deceased Child, Male, 2 Days	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 2 Days	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Substantiated	

Sibling, Female, 1 Years	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 1 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Male, 12 Years	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 1 Years	Other Adult - BF of 1yo SS, Male, 30 Years	Inadequate Guardianship	Substantiated

Report Summary:
This SCR report was received with concerns SM was pregnant, had a history of seizures and abused alcohol, and had the 1yo SS in her care. SM and the 1yo SS were staying with the 1yo's BF; however, the BF had SM leave his home due to her drinking. SM took the 1yo SS with her. SM and the SS stayed at a motel and other various places. On 2/23/21, SM was found unresponsive in her motel room, and the 1yo SS was also present. SM was transported to the hospital, and SC was born via C-section. SM's substance abuse and mental health concerns impaired her ability to care for the 1yo SS, and SM would have been unable to care for SC.

Report Determination: Indicated | **Date of Determination:** 03/30/2021

Basis for Determination:
OCDSS interviewed family members and collateral sources. SM and the 1yo were homeless after being forced to leave BF's home due to SM's alcoholism. SM was found unresponsive at a motel where she and the 1yo were staying. The 12yo was with the MGM, and after SM's hospitalization, she also took the 1yo into her care. Both SSs were assessed as safe. SC was born unresponsive and died on 2/27/21. SM died on 3/22/21. The 1yo's BF was interviewed, and attempts were made to interview the 12yo's BF but were unsuccessful. The 1yo's BF was arrested during the investigation for an unrelated warrant and incarcerated. The 12yo's BF had been incarcerated prior to this investigation. The allegations against SM and the 1yo's BF were substantiated. A neglect petition was filed against the 1yo's BF because he allowed SM to leave his home with the 1yo despite knowing she was intoxicated, homeless, and unable to provide adequate care of the child. MGM was awarded custody of both SSs, and a court ordered services case was opened in response to this investigation.

OCFS Review Results:
This investigation met all statutory requirements.

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)
07/30/2020	Sibling, Female, 1 Years	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 1 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 1 Years	Other Adult - PS, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that on 7/26/20, the parent substitute (PS) was physically aggressive toward SM while the 1yo SS was present in the home. There were additional concerns SM was the sole caretaker of the SS while under the influence of alcohol.

Report Determination: Indicated | **Date of Determination:** 10/16/2020

Basis for Determination:
OCDSS interviewed SM, who admitted she was intoxicated and involved in a physical altercation with PS. When LE

responded, SM arranged for SS to stay with MU. OCDSS reviewed with SM, MU and BF that a sober caretaker was always needed. SM was in mental health treatment and OCDSS spoke with her counselor. The counselor reported SM was compliant and had no concerns. The PS could not be located during this investigation. The BF of the 1yo SS was interviewed and he stated SM would ask him or MU to watch the SS if she began drinking. By the close of the investigation, SM and the 1yo SS had moved in with MU. BF and MU's homes were observed with no concerns noted, and the 1yo SS was assessed as safe.

OCFS Review Results:
SM reported the 12yo SS was staying with a relative; however, OCDSS did not ask any follow up questions, nor make attempts to meet with this child or his caretaker. The 1yo SS's medical records indicated she was referred to specialists regarding developmental delays; however, OCDSS did not follow up with SM nor BF to confirm the SS was receiving the recommended care. Safety assessments noted there were no safety factors present; however, SM admitted to abusing alcohol to the extent that it negatively impacted her ability to care for SS. BF reported to OCDSS that SM was pregnant; however, OCDSS did not follow up with SM about this to offer services or provide safe sleep information.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
OCDSS was made aware by SM that she had a 12yo child who was staying with a relative. The record did not reflect any attempts were made to speak with this child or his caregiver.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
The 1yo SS's medical records indicated she was referred to specialists regarding developmental delays. The record did not reflect if OCDSS followed up with SM or BF to confirm the SS was receiving the recommended care.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
Throughout the CPS investigation, CCDSS must facilitate information gathering, analyses of safety factors and the inter-relatedness of risk influences and individual risk elements affecting family functioning.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The Seven Day Safety Assessment noted there were no safety factors present; however, SM admitted to abusing alcohol to the extent that it negatively impacted her ability to care for SS.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Within seven days of receiving a report, OCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Issue:
Failure to provide safe sleep education/information

Summary:
BF reported to OCDSS that SM was pregnant. The record did not reflect OCDSS followed up with SM about this to offer her services and information regarding safe sleep practices.

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

Action:
OCDSS will provide information on sleep safety to the parents and caretakers of infants whom they encounter, and see that necessary steps are taken to provide safe sleeping conditions for the children in their care.

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

The mother was named as a subject in one FAR investigation and one indicated CPS investigation in 2016. The mother was indicated for IG and PD/AM.

The biological father of the 12-year-old sibling was named in two unfounded reports in 2017. The allegations in those reports were IG and XCP.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A voluntary preventive services case was opened in 2015 after a referral from the now 12-year-old surviving sibling's school. The school had concerns regarding the sibling's behaviors and interactions with other children. The sibling was placed in a different class setting and improved. The mother expressed difficulty with parenting and was linked to a parent aid. The mother was also referred to a mental health counselor. In March 2016, the mother requested the case be closed due to having supports in place.

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