Child Fatality Report

Report Identification Number: SY-22-009

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

Issue Date: Jun 10, 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	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Madison
Gender: Male
Date of Death: 02/19/2022
Initial Date OCFS Notified: 02/19/2022

Presenting Information

Madison County Department of Social Services (MCDSS) received an SCR report on 2/19/2022 which alleged that on that day, around 6 AM, the mother (SM) and her paramour placed the 2-month-old child (SC) to sleep on a recliner chair with a blanket under him and then went to bed themselves. Around 1:00 PM, the SM and paramour found the SC face-down and unresponsive in the corner of the recliner chair. Subsequent and duplicate SCR reports were also received. There was conflicting information in the 3 SCR reports received, with 1 report alleging the SM had periodically checked on the SC throughout the morning and the other 2 reports alleging the SM and paramour did not check on the SC between 6:00 AM and 1:00 PM. Additionally, 1 of the reports alleged that the SC sustained bruising to his forehead. A call was made to 911 at 1:13 PM and the SC was transported to the hospital where he was pronounced deceased at 1:50 PM.

Executive Summary

This report concerns the death of the 2-month-old child who died during an open CPS investigation. The investigation open at the time of the death regarded concerns that the child was being left in the care of his maternal grandmother, who was an inappropriate caregiver. At the time of the child's death, he resided with his mother and maternal grandmother. The child had a 1yo sibling who resided with his paternal great-grandmother, and he was assessed to be safe. At the time of his death, the child and mother were visiting the home of the paramour, where the paramour resided with his mother and stepfather. The record reflects that the mother and child regularly visited this home and that the mother would consistently place the child to sleep on a recliner chair in the paramour's bedroom, while the mother and paramour would sleep on a bed in that same room.

MCDSS received a preliminary autopsy report from the medical examiner, with findings that the death was consistent with a terminal face-down sleeping position. The official cause of death remained pending at the time of this writing. Law enforcement was conducting an investigation into the death; however, the outcome of their investigation remained unknown. The record did not reflect criminal charges were filed, and the record reflected MCDSS learned from LE that they were awaiting instruction from the DA regarding potential charges.

The reported allegations of DOA/Fatality and Inadequate Guardianship, as well as the added allegation of Lack of Supervision, were substantiated against the mother. MCDSS determined that the mother was aware of safe sleep practices and was in possession of both a portable crib and bassinet; however, she did not utilize either when she placed the child to sleep on top of a blanket on a recliner chair, which directly contributed to the child's death.

The reported allegations of DOA/Fatality and Inadequate Guardianship were unsubstantiated against the mother's paramour. MCDSS noted in the investigation conclusion that the paramour was not a person legally responsible for the care of the child as he did not feed, change, put to sleep, or babysit the child. This information; however, was not reflected elsewhere in the case record.

The allegation of Lacerations / Bruises / Welts was unsubstantiated against both the mother and paramour. MCDSS determined through interviews with hospital staff that the marks observed on the child which were thought to be bruising, were in fact mottling of the skin, a result of the length of time that had passed since child's death.

MCDSS missed multiple opportunities to gather pertinent information related to the circumstances of the child's death.

MCDSS did not question the paramour or his mother about substance misuse prior to or during the time of the fatal incident. MCDSS did not interview the paramour's step-father, who was in the home at the time of the child's death. The case record reflected discrepancies in reports given to LE and CPS by mother, paramour, and the paramour's parents, regarding the timeline of events surrounding the child's death. The most significant of those discrepancies was that the mother and paramour reported to LE that the child was found unresponsive at 11:30 AM or 12:00 PM; however, records gathered from EMS showed that 911 was not contacted until 1:13 PM. Other discrepancies included conflicting reports as to when the child was placed to sleep, and if he was checked on at any point in the 6-hour period prior to him being found unresponsive. MCDSS did not document a discussion of the discrepancies with any person.

MCDSS filed an Abuse petition against the mother, with derivative allegations regarding the sibling, although no allegations were added for the sibling to the CPS investigation. MCDSS opened a Preventive Services Case for the family as the petition was pending. MCDSS referred all adults for grief counseling services.

PIP Requirement
MCDSS will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the MCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDSS 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?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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:
The case record contained documentation of supervisory consultation and the case was appropriately opened for services pursuant to the concerns for the surviving sibling.

Required Actions Related to the Fatality

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

Issue:	Determination of Nature, Extent and Cause of Conditions (Report)
Summary:	Although a petition was filed regarding the sibling, the record did not reflect an allegation was added to the investigation regarding the sibling.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	MCDSS will appropriately add and determine allegations regarding the nature, extent and cause of any condition enumerated in such report and any other condition that may constitute abuse or maltreatment.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Although the SM and paramour were interviewed, the record did not reflect discussions regarding the discrepancies of timelines the family provided.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	MCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect the paramour's step-father was interviewed despite his presence in the home at the time of the fatal incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	MCDSS 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:	Failure to provide notice of report
Summary:	Although the SM and SC resided in the home of the maternal grandmother, she was not added to the report or provided written notice.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	MCDSS will mail or deliver notification letters to subject(s), parent(s), 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/19/2022 **Time of Death:** 01:50 PM

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

County where fatality incident occurred: Madison
Was 911 or local emergency number called? Yes
Time of Call: 01:13 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 6 Hours
At time of incident was supervisor impaired? Unknown if they were 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	2 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)
Other Household 1	Mother's Partner	Alleged Perpetrator	Male	20 Year(s)

LDSS Response

On 2/19/2022, MCDSS contacted the source of the SCR report, spoke with LE, and verified there were no other children residing with the SM or her paramour. MCDSS conducted a history search for all home members.

MCDSS attempted to interview the mother on 2/20/22 but she declined. MCDSS made diligent attempts to interview the mother thereafter; however, she declined to provide information to MCDSS.

MCDSS gathered information from LE, EMS, and ME and learned that the SC was placed to bed between 6:00 AM and 7:00 AM by the SM, who then went to sleep herself. The SC was placed to sleep on his back on a comforter atop a recliner chair in the bedroom of the paramour, where the SM and her paramour were also sleeping. The SM found the SC unresponsive about 6 hours later in a face-down position, wedged into the corner of the chair. The paramour's mother performed CPR while 911 was called and until EMS arrived. The SC was transported to the hospital where he was pronounced deceased.

MCDSS met with the paternal great-grandmother, (PGGM) who had custody of the 1yo SS. The PGGM reported concerns for the SM's ability to care for her children including an incident when the SM returned the SS to the PGGM's home without a car seat. A safety plan was put in place that the SM would have no unsupervised contact with the SS. MCDSS met with the biological father of the SC and SS, who resided in the home of the PGGM. The BF was interviewed but had no specific information regarding the SC's death.

MCDSS gathered records from LE which included statements made by the SM, paramour, first responders, and the paramour's mother and step-father. These statements contained conflicting reports regarding when the SC was put to sleep, if and when he was checked on, and when he was found unresponsive. The record did not reflect MCDSS questioned the family about these conflicting reports.

MCDSS requested and was provided with a preliminary autopsy report. That report noted the skin color / pallor surrounding the SC's mouth and nose to be consistent with a terminal face-down sleeping position. The report noted no injuries or evidence of natural disease. The cause of death was, and remains as of this writing, pending.

MCDSS attempted to engage the SM with the investigation on multiple occasions and she declined to discuss the death of the SC. The SM reported to other family members that she had heard from the ME that her child died from "SIDS" and that she was not responsible for his death. Through contact with the SM as well as several other family members, it was learned that the SM was aware of safe sleep practices and did have a portable crib and a bassinet for the SC. At the time of the SC's death, the SM and SC were staying at the home of the paramour's parents where there was no safe sleep arrangement, despite their staying at this home being a regular occurrence. Through these contacts it was also learned that SC had rolled over by himself for the first time only days prior to this incident.

Although MCDSS asked the SM about general alcohol and drug misuse, MCDSS did not document a discussion regarding whether or not the mother used or misused drugs or alcohol on 2/19/22. The record did not reflect the paramour, or his mother were asked about drug or alcohol misuse. Additionally, the record did not reflect an interview with the paramour's stepfather occurred, although he was in the home at the time of the death.

MCDSS filed a petition against the SM due to concerns for her ability to care for the SS and the case was opened for preventive services.

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?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

059785 - Deceased Child, Male, 2 Mons	059786 - Mother, Female, 18 Year(s)	DOA / Fatality	Substantiated
059785 - Deceased Child, Male, 2 Mons	059786 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Substantiated
059785 - Deceased Child, Male, 2 Mons	059786 - Mother, Female, 18 Year(s)	Lack of Supervision	Substantiated
059785 - Deceased Child, Male, 2 Mons	059786 - Mother, Female, 18 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated

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?	☐	☒	☐	☐
Other	☐	☒	☐	☐
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:

Although he was in the home at the time of the child's death, the record does not reflect that the paramour's step-father was interviewed.

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:
MCDSS attempted to engage the SM with services but she declined. MCDSS filed a petition against the SM.

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?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**

04/19/2022	There was not a fact finding	There was not a disposition
Respondent:	059786 Mother Female 18 Year(s)	
Comments:	A petition was filed by MCDSS against SM with regards to the SS. There was not yet any fact finding or disposition as of this writing.	

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:
MCDSS did offer and attempt to engage the SM with services; however, she declined to engage. Bereavement services were also offered to all adults in the case composition.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
The sibling was too young to benefit from services in response to the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:
MCDSS provided counseling information to all adults in the case composition.

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)
12/29/2021	Deceased Child, Male, 1 Months	Mother, Female, 18 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 1 Months	Grandparent, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
MCDSS received an SCR report on 12/29/2021 which alleged that the SM was leaving the SC in the care of the MGM who was an unsuitable caretaker. The MGM previously had her own children removed from her due to her substance misuse, was not engaged in treatment, and therefore had been unable to regain custody.

Report Determination: Unfounded **Date of Determination:** 02/25/2022

Basis for Determination:
MCDSS interviewed the SM and MGM who both denied the SC was left alone with the MGM. Unannounced home visits corroborated this information and no evidence was found to substantiate the allegations.

OCFS Review Results:
MCDSS added the BF to the case and mailed a notification letter; however, made no further attempt to meet with him face-to-face or otherwise engage him in the investigation. The initial SCR report listed the SM's boyfriend with an incorrect name and the SM and MGM denied knowing who this person was. A subsequent SCR report was received by

MCDSS during the open case with the correct demographic information for this person and MCDSS did not update the case record to reflect this, nor did they make an attempt to speak with this person. Progress notes were entered over 30 days after the corresponding case event.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Progress notes were not entered contemporaneously to their event dates, with 11 out of 19 progress notes being entered more than 30 days after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
Although the father was added to the case, the record did not reflect attempts were made to contact him.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
MCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Case record contains information that is relevant, useful, factual and objective
Summary:
Although the subsequent report contained identifying information regarding the SM’s boyfriend, the record did not reflect MCDSS updated the information within Connections.
Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:
MCDSS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
MCDSS missed opportunities to gather collateral information, such as: the SC's pediatrician and the Maternal Great-Grandmother (MGGM), who was the supervisor for the SM's visits with the SS.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
MCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/09/2021	Sibling, Male, 3 Months	Mother, Female, 17 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 3 Months	Father, Male, 17 Years	Inadequate Guardianship	Substantiated	

Report Summary:
Oneida County Department of Social Services (OCDSS) received an SCR report on 02/09/2021 alleging the SM and BF were engaging in fist fights in the presence of the then 3-month-old SS, the report alleged that the SM had mental health issues and thoughts of self-harm.

Report Determination: Indicated | **Date of Determination:** 09/22/2021

Basis for Determination:
The investigation revealed there was DV between the SM and BF as there was an incident when the parents threw and damaged property in the presence of the SS, which led to the allegation of IG being substantiated against both parents. The PGGM applied for and was granted primary physical custody of the SS.

OCFS Review Results:
The safety of the sibling was not assessed timely and face-to-face contacts were not adequate.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The record did not reflect OCDSS made face-to-face contact with the PGGM and SS, or attempt at such contact, between the receipt of the 2/9/2021 report and 6/29/2021 and there was no documented casework activity between 2/17/2021 and 6/7/2021.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
OCDSS must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed.

PIP Requirement:
For citations identified in historical cases, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/30/2020	Sibling, Male, 1 Days	Mother, Female, 17 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 1 Days	Father, Male, 17 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Days	Mother, Female, 17 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
MCDSS received an SCR report on 10/30/2020 which alleged the SM gave birth to the then newborn SS and both tested positive for THC at the time of delivery. After initial contact, it was determined the family was residing in Oneida County and the case was transferred on 11/12/2020 to OCDSS. A subsequent report was received by OCDSS on 11/23/2020, with allegations that the SM and BF were throwing objects in the presence of the SS.

Report Determination: Indicated | **Date of Determination:** 09/21/2021

Basis for Determination:
Concerns were documented throughout the investigation for the SM and BF throwing objects in the presence of the SS, which led to the allegations of IG being substantiated against both parents. The allegation of PD/AM was unsubstantiated as the SS did not exhibit withdrawal symptoms and OCDSS found no evidence of a negative effect on the child due to the SM's marijuana use. The PGGM applied for and was granted primary physical custody of the SS.

OCFS Review Results:
OCDSS did not assess the safety of the child timely. The record did not reflect adequate information was gathered from collateral contacts. The case record reflected periods when the safety of the children was unknown.

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

Issue:
Failure to provide notice of report
Summary:
The record did not reflect MCDSS provided the parents with written notice of the SCR reports.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
MCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day safety assessment was completed untimely on 11/10/2020.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
MCDSS will document and approve all safety assessments within the required timeframe.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Progress notes were not entered contemporaneously to their event dates, 12 out of 59 notes were entered more than 30 days after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.
PIP Requirement:
For citations identified in historical cases, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:

The record did not reflect OCDSS made contact or attempted to make contact with the family between 11/4/20 and 2/10/20 and again from 2/12/21 and 6/29/21, and no further contact was made between 6/29/21 and 9/21/21. The SS was not seen between 11/4/20 and 6/29/21.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

OCDSS must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed.

PIP Requirement:

For citations identified in historical cases, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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.

Issue:

Timely Commencement of Investigation

Summary:

Although a subsequent report was received on 11/23/20 and appropriately consolidated into the initial report, the record did not reflect casework activity until 2/10/21.

Legal Reference:

SSL 424(6);18 NYCRR 432.2(b)(3)(i)

Action:

OCDSS will commence, within 24 hours, an appropriate investigation for each report of suspected child abuse and/or maltreatment.

PIP Requirement:

For citations identified in historical cases, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known 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.

Additional Local District Comments

Upon reviewing the report, Oneida County Department of Social Services had the following comments: Regarding the period 6/29/21 – 9/21/21, although SS had not been seen at a face to face contact, child had been in the primary custody of non-subject PGM. OCDSS did have contacts with pediatrician on two occasions. SS was up to date with well child visits and pediatrician had no concerns for child's care. Also, PGM was participating in Healthy Families and OCDSS had contact with provider who noted no concerns for SS with PGM.

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