Child Fatality Report

Report Identification Number: SY-20-049

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

Issue Date: Apr 05, 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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Cortland
Gender: Female
Date of Death: 10/25/2020
Initial Date OCFS Notified: 10/25/2020

Presenting Information

On 10/25/20, Cortland County Department of Social Services (CCDSS) received an SCR report that stated the mother woke up and fed the subject child around 3:00AM. After feeding and burping the child, the mother laid her back to sleep on the parents' bed between she and the father. The parents woke around 7:15AM and saw the child was not breathing. The mother called 911 and the parents moved the child to the kitchen where they placed her on the floor and performed CPR. EMS arrived sometime before 7:50AM and determined the child was deceased. The child was otherwise healthy and the parents had no explanation for her death.

Executive Summary

On 10/25/20, CCDSS received an SCR report regarding the death of the 1-month-old subject child that occurred on the same day. The child resided with her mother, father, 16-year-old sibling, 14-year-old sibling and 8-year-old sibling. At the time of the fatality, the child was home with the parents, 14-year-old sibling and two cousins, who were having a sleep over with the sibling. The 8-year-old sibling was at an aunt's home and the 16-year-old sibling was at a friend's house. The surviving siblings and cousins were assessed to be safe with their parents.

CCDSS coordinated investigative efforts with law enforcement and learned that on the night of 10/24/20, between 10:00PM and 11:00PM, the mother, father and subject child went to the parents' bedroom to go to sleep. The father fell asleep by 11:00PM. The mother bottle fed the child then placed her to sleep between she and the father on their bed and fell asleep around 1:00AM. The mother woke and fed the subject child between 2:00AM and 3:00AM and then placed her back to sleep between she and the father. The father woke around 7:00AM and left the room. The father then heard the mothering screaming. The mother found the subject child unresponsive in the bed next to her. The father attempted CPR and the mother called the grandmother. The grandmother lived a short distance away and immediately responded to the home and took over resuscitation efforts. The father called 911 and first responders arrived and attempted to revive the subject child; however, their efforts were unsuccessful and the child was declared deceased. The child was transported from the home to the medical examiner's office for an autopsy.

Law enforcement had not found any criminality related to the death at the time the CPS investigation was closed. An autopsy was performed and the cause of death was sudden death associated with an unsafe sleeping environment. The autopsy further stated that although the sleeping environment strongly raised the possibility of accidental suffocation/overlaying, it could not be established scientifically; therefore, the manner of death was undetermined.

Due to the father's substance abuse history and concerns of drug paraphernalia found in the home, CCDSS conferenced with their Legal Department and it was determined they would not proceed with an Article 10 petition. Law enforcement reported the drug paraphernalia appeared as if it was not recently used. The interviews of the children did not support any concerns of drug use in the home. CCDSS spoke to the father's substance abuse counselor and learned that he was compliant with recommended treatment. CCDSS offered the family voluntary preventive services, which they declined.

CCDSS offered and provided mental health counseling, funeral arrangements, and age appropriate care packages from the Child Advocacy Center. The parents had the siblings enrolled in school-based mental health counseling at the time of case closure.

There was sufficient information gathered through collateral and casework contacts to substantiate the allegations against

parents. It was determined that the parents co-slept with the subject child and on the night of the fatal incident, the child was placed in an unsafe sleep environment, which was determined to have contributed to her death. The investigation was indicated and closed on 12/21/20.

PIP Requirement
CCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) CCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDSS 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?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
All required casework activity was completed and documented in connections.

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, the case record has detail of the consultation.

Explain:
CCDSS completed all casework activities commensurate with case circumstances. Preventive services and referrals for community services were offered to the family, which the family declined and the investigation was closed.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment

Child Fatality Report

Summary:	Although safety of the surviving children was assessed at 30 days after the receipt of the SCR report, the safety assessment tool was submitted and approved late on 12/2/20.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	CCDSS must complete a safety assessment at 30 days for reports of a child fatality, unless there are no surviving siblings or children in the household. This is in addition to the 24-hour assessment, the seven-day assessment and the conclusion safety assessment that must be completed within seven days prior to closing the case.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/25/2020 **Time of Death:** 07:51 AM

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

County where fatality incident occurred: Cortland
Was 911 or local emergency number called? Yes
Time of Call: 07:40 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 4 Hours
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	Female	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	42 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	No Role	Female	16 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Other Household 1	Other Adult - Mother of 16yo sibling	No Role	Female	38 Year(s)
Other Household 2	Other Adult - Father of 8yo sibling	No Role	Male	36 Year(s)

LDSS Response

CCDSS received an SCR report on 10/25/20 regarding the death of the subject child. CCDSS initiated their investigation, contacted LE, notified the district attorney's office, spoke to the medical examiner, and contacted the source of the report.

CCDSS conducted joint interviews of the mother and father regarding the fatal incident. The night prior to the fatality, the two cousins were at the home for a sleep over with the 14-year-old sibling. The father was at work until 9:00PM. When he returned home, he made himself dinner, and then he and the mother went to their bedroom between 10:00PM and 11:00PM. The mother fed the subject child. The father was asleep by 11:00PM, and the mother reported that she was awake until 1:00AM. The mother went to sleep and placed the child in the bed between her and the father. The mother stated that between 2:00AM and 3:00AM, she woke up and fed the child. She denied noticing anything wrong with the child. After she fed the child, she again placed her to sleep between she and the father. Further details regarding the child's positioning were not documented. The father woke up at approximately 7:15AM. He reported he went upstairs to use the bathroom and then heard the mother screaming. The mother reported she found the subject child unresponsive, purple and with blood coming out of her nose. She checked to see if the child was choking and put her finger in the back of the child's throat to clear any potential obstructions, but did not find anything. The father attempted to perform CPR on the child, and the mother called the grandmother. The grandmother lived nearby and went to the home immediately. The grandmother arrived and took over the resuscitation efforts. The father called 911. When first responders arrived they attempted to revive the child, but were unsuccessful.

The parents reported it was not typical for the subject child to sleep in the bed with them. There was a Pack-N-Play in the home, but they did not use it the night of the fatality because it was filled with laundry due to their washing machine being broken. The parents further reported that they had slept with the subject child between them in their bed before. When questioned about safe sleep practices, the parents reported they had learned about safe sleep guidelines in the hospital.

The grandmother, cousins and siblings were interviewed and provided the same accounts of the events leading up to the fatality. There were no additional safety concerns enumerated during the interviews. The father of the 8-year-old sibling and mother of the 16-year-old sibling were interviewed and had no information to contribute regarding the fatality and no concerns about the parents' care of the children. The father of the 14-year-old sibling was unknown.

CCDSS spoke to numerous collaterals to obtain information regarding the fatality. Law enforcement expressed some concern for the condition of the home, including drug paraphernalia found in the parents' bedroom and an exposed electrical panel. The father had a history of substance abuse; however, reported he was sober and the drug paraphernalia was old. Law enforcement confirmed the paraphernalia did not appear as if it was recently used and neither parent appeared under the influence during their interactions with them. The father took a drug screen a month after the fatality and was negative for all illicit substances. The family did not return to the case address following the fatality and stayed with the grandmother.

Official Manner and Cause of Death

Official Manner: Undetermined

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

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Cortland County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056527 - Deceased Child, Female, 1 Mons	056528 - Mother, Female, 28 Year(s)	DOA / Fatality	Substantiated
056527 - Deceased Child, Female, 1 Mons	056528 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
056527 - Deceased Child, Female, 1 Mons	056529 - Father, Male, 42 Year(s)	DOA / Fatality	Substantiated
056527 - Deceased Child, Female, 1 Mons	056529 - Father, Male, 42 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:
The father of the 8-year-old sibling was incarcerated. CCDSS completed and documented an interview with him via telephone.

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:
CCDSS assessed for the needs of the family and offered relevant community services. CCDSS documented a conference with their Legal Department and it was determined an Article 10 petition would not be filed. The family was offered voluntary preventive services, which they declined.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine

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

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The surviving children were offered mental health counseling, care packages and services through the CAC.

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 mental health counseling, funeral arrangements and services through the CAC. In addition, the parents were offered voluntary preventive services, which they declined.

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?	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)
01/15/2020	Sibling, Female, 14 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 7 Years	Mother, Female, 27 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 27 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 27 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 27 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Sibling, Male, 7 Years	Father, Male, 41 Years	Educational Neglect	Unsubstantiated
Sibling, Male, 7 Years	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 7 Years	Father, Male, 41 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
An SCR report received by CCDSS alleged that the mother and father were aware the now 8yo SS had been absent from school for 27 days and was falling behind in grade level as a result. When absent, the sibling missed medically necessary services including mental health counseling. The parents took no action to address the concern. On 1/31/20, a subsequent report was received with concerns that the mother was physically aggressive toward the 14yo SS when trying to get her out of bed to go to school. On 2/12/20, a subsequent report was received with concerns that the mother slapped the 8yo sibling in the face and left a mark.

Report Determination: Unfounded | **Date of Determination:** 05/01/2020

Basis for Determination:
CCDSS unsubstantiated the allegations regarding the now 8yo SS. It was determined through casework and collateral contacts that the SS displayed defiant behaviors and the parent's experienced challenges with him. When the SS was acting out physically the SF would attempt to stop him, which caused a mark on the sibling's face. The SF reported it was accidental and the SS was not able to identify if it was accidental or purposeful. The SS was in receipt of services for his behaviors. The allegation regarding the now 14yo SS was unsubstantiated. The SS reported she had slapped the SM and then they proceeded to slap each other. The SM denied the allegations.

OCFS Review Results:
CCDSS documented efforts to contact the absent parents. CCDSS offered the family referrals for community services, which were declined. It was learned during the investigation that the mother was pregnant with the subject child and it was not documented that safe sleep guidance was provided. Several progress notes were not entered contemporaneously with their event date and not all required face-to-face interviews were completed. It was not documented that the source of the initial report was contacted.

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

Issue:
Failure to provide safe sleep education/information

Summary:
It was documented that mother was pregnant with the subject child and the record did not reflect that safe sleep guidance was provided.

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

Action:
CCDSS will provide safe sleep guidance to the parents and caretakers of infants and expecting parents whom they encounter and see that the parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

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

Summary:
The grandmother was listed on the SCR report and the record did not reflect attempts to interview her regarding the SCR report.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:
The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Approximately 10 notes were entered more than a month after their event date.
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:
Contact/Information From Reporting/Collateral Source
Summary:
Although a phone call was made to one of the sources, the record did not reflect the source of the initial SCR report was contacted.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
CCDSS will contact, or make diligent efforts to contact, the source of all SCR reports so as to verify adequacy of report and possibly glean additional information. CCDSS will document the contact or attempts at contact.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/23/2019	Sibling, Female, 13 Years	Mother, Female, 27 Years	Educational Neglect	Unsubstantiated	Yes

Report Summary:
An SCR report received by CCDSS alleged that the now 14-year-old sibling had missed 8 out of 14 days of school and was failing as a result. The sibling missed 36 days the previous school year. The school called and emailed the mother and the father and they failed to respond. It was unknown why the sibling was not attending. The now 16-year-old sibling had an unknown role.

Report Determination: Unfounded | **Date of Determination:** 05/01/2020

Basis for Determination:
CCDSS determined the sibling often would refuse to attend school and when she did attend school she would not participate. The mother made efforts to get the sibling to attend and then switched the child's school to increase the sibling's participation. At the time the SCR report was received, the father and now 16-year-old sibling were not residing in the home and their role was changed to reflect that they were added to the SCR report in error. CCDSS determined there was not enough credible evidence to substantiate the allegations.

OCFS Review Results:
CCDSS assessed safety of the siblings within 24 hours of receipt of the SCR report. All necessary familial and collaterals contacts were made. CCDSS documented efforts to contact the absent parents. CCDSS offered the family referrals for community services, which were declined. It was learned during the investigation that the mother was pregnant with the subject child and it was not documented that safe sleep guidance was provided. Several progress notes were not entered contemporaneously with their event date and the 7-day safety assessment tool was completed late in Connections.

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

Issue:
Failure to provide safe sleep education/information
Summary:

It was documented that mother was pregnant with the subject child and the record did not reflect that safe sleep guidance was provided.

Legal Reference:

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

Action:

CCDSS will provide safe sleep guidance to the parents and caretakers of infants and expecting parents whom they encounter and see that the parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

Although the record reflected safety of the siblings was assessed within 7 days of receipt of the SCR report, the safety assessment tool was submitted and approved late in Connections.

Legal Reference:

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

Action:

CCDSS will document and approve all safety assessments within the required time frame

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Approximately 14 of the progress notes were entered more than a month after their event date.

Legal Reference:

18 NYCRR 428.5

Action:

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/09/2018	Sibling, Male, 5 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 5 Years	Mother, Female, 26 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:

An SCR report received by CCDSS alleged on 2/8/18, the mother forcefully spanked the now 8-year-old sibling with a closed fist. It was unknown if the sibling sustained any injuries as a result. The sibling had bruising on his cheek and chin. Further details regarding the bruising were unknown. The roles of the father, now 16-year-old sibling and now 14-year-old sibling were unknown.

Report Determination: Unfounded | **Date of Determination:** 07/16/2018

Basis for Determination:

CCDSS unfounded the report as they determined there was no credible evidence to support the allegations. The mother denied the allegations and the sibling had no marks or bruises on him.

OCFS Review Results:

CCDSS assessed safety of the siblings within 24 hours of receipt of the SCR report. All casework activity was completed commensurate with case circumstances. CCDSS offered relevant referrals for community services.

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

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

Between 2012 and 2017, the mother had 4 unfounded CPS investigations. Allegations included XCP, L/B/W and IG and were in regards to the surviving siblings. The mother had 1 indicated CPS investigations with a substantiated allegation of IG and L/B/W regarding the now 8-year-old sibling.

Between 2007 and 2017, the father had 5 unfounded CPS investigations. Allegations included IG, PD/AM, L/B/W and IF/C/S regarding the surviving siblings. The father had 5 indicated CPS investigations with substantiated allegations of IG, EdN, LMC and PD/AM regarding the now 16-year-old sibling. In addition, the father had a CPS FAR case with concerns regarding the 16-year-old sibling's education.

In 2012, there was an indicated CPS investigation with the allegations of IG and PD/AM regarding the 16-year-old sibling against her mother. In 2014, there was an unfounded CPS investigation with the allegation of IG regarding 16-year-old against her Article 6 guardians.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Preventive Services History

In December 2015, CCDSS opened a voluntary preventive case after an indicated SCR report regarding the mother using excessive physical discipline on the now 8-year-old sibling. The parents completed parenting classes and then requested their case be closed in February 2016.

Between December 2012 and August 2015, the father had a mandated preventive case regarding the now 16-year-old SS. The case was opened after an indicated SCR report against the sibling's mother with concerns about the sibling's educational and medical needs not being met and the sibling's mother's substance abuse. The sibling's mother was arrested for a violation of probation due to her drug use and went to court ordered rehabilitation. The SS went to live with the father. A neglect was filed against the sibling's mother and she was court ordered services to address the child welfare concerns. In July 2013, the father and sibling's mother were arrested for endangering the welfare of a child after being found in a hotel room with marijuana, opiates and drug paraphernalia with the SS present. CCDSS also filed a Neglect petition against the father and he was court ordered services. The SS was placed with a relative through a 1017 placement. The father and sibling's mother failed to complete services and on 7/29/15 the relative was granted custody through an Article 6 custody petition and the case closed.

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