Child Fatality Report

Report Identification Number: AL-22-012

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

Issue Date: Sep 02, 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: 30 day(s)
Jurisdiction: Montgomery
Gender: Male
Date of Death: 03/31/2022
Initial Date OCFS Notified: 03/31/2022

Presenting Information

Montgomery County Department of Social Services (MCDSS) received an SCR report alleging on 3/31/2022, at approximately 4:30AM, the mother found the 30-day-old subject child deceased. On 3/30/2022, at 10:30PM, the mother went to sleep with the subject child and 3-year-old surviving sibling in her bed. The mother slept between the children. The mother breast fed the subject child at 12:30AM, and again at 2:30AM. When the mother awoke at approximately 4:30AM, she noticed the subject child was lying on his back, cold and not breathing. The mother brought the subject child downstairs to the maternal grandmother's bedroom. The grandmother and mother attempted cardiopulmonary resuscitation on the subject child, while they called 911. The subject child was not revived and the cause of death was unknown at the time if the report. The mother and grandmother did not have an explanation for the subject child's death, and it was unknown if unsafe sleep practices contributed to the death.

Executive Summary

This fatality concerns the death of a 30-day-old male subject child that occurred on 3/31/22. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother and maternal grandmother. At the time of his death, the subject child resided with his mother, maternal grandmother and 3-year-old sibling. The father of the subject child had a warrant out for his arrest at the time of the death for charges unrelated to the fatality and was unable to be located during the investigation. The father of the sibling resided in a separate household. There was an open CPS investigation at the time of the fatality regarding domestic violence by the father toward the mother.

Montgomery County Department of Social Services (MCDSS) completed collateral contacts and casework activity and learned that on 3/30/22, the mother put the 3-year-old sibling into bed with her and the subject child. The mother reported that she and the subject child fell asleep while she was breastfeeding the subject child, which was a normal occurrence. The mother reported the sibling was near the wall, the subject child was in the middle on his back with his face toward the mother’s breast, and the mother was on the opposite side from the sibling. The mother woke up around 12:30AM and breastfed the subject child again. At approximately 4:00AM, the mother woke up and found the subject child still lying on his back, and unresponsive. The mother attempted rescue breaths on the subject child, and then brought the subject child to the maternal grandmother who continued to give rescue breaths and called 911. Emergency medical services, law enforcement and the coroner responded to the residence, and the subject child was pronounced deceased.

MCDSS received the final autopsy report which stated the autopsy showed pulmonary congestion and a partial collapse of the lung. While non-specific, this finding is suggestive of a possible object, including a bedmate’s body part on the lower face at time of death. The child’s toxicology revealed norbuprenorphine in the urine which was most likely from the mother’s breastmilk. The report also stated that a co-sleeping adult on buprenorphine may not exhibit a level of vigilance necessary to avoid an accidental rollover onto newborn.

The allegations of DOA/Fatality and Inadequate Guardianship were substantiated against the mother; however, unsubstantiated against the maternal grandmother. MCDSS found there to be a fair preponderance of evidence to support that the mother was aware of safe sleep practices and had multiple safe sleep provisions for the subject child; however, she regularly co-slept with the subject child, and the autopsy suggested the subject child’s death was a result of co-sleeping. MCDSS offered the family bereavement and counseling services. The mother stated she was not ready to

engage in counseling at the time, while the grandmother had begun counseling through a previously established service provider. The case was indicated and closed on 6/2/22.

PIP Requirement

This review resulted in a citation related to casework practice. In response, MCDSS will submit a PIP to Albany Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the MCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, MCDSS 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:**
  - **Approved Initial Safety Assessment?** No
  - **Safety assessment due at the time of determination?** No
- **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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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:

MCDSS made an appropriate determination based on evidence gathered throughout the investigation. Although all other casework activity was commensurate with case circumstances, the 24-hour, 7-day and 30-day safety assessment tools were completed in relation to the subject child, and did not reflect the safety of the surviving sibling.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment

Summary:	The safety assessment tool was completed incorrectly, as it only addressed the deceased child and not the surviving sibling. The record does not reflect that key information was obtained from the mother pertaining to her medication use to further assess the sibling's safety.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	MCDSS will document and approve all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/31/2022 **Time of Death:** 04:30 AM (Approximate)

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

County where fatality incident occurred: Montgomery
Was 911 or local emergency number called? Yes
Time of Call: 04:47 AM
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? 4 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	30 Day(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Father	No Role	Male	23 Year(s)
Other Household 2	Father	No Role	Male	23 Year(s)

LDSS Response

MCDSS coordinated their investigation with LE, notified the DA's office and ME of the death, spoke with collateral sources and interviewed household members.

MCDSS interviewed the mother and maternal grandmother separately on 3/31/22. The mother reported that around 10:00PM she put the sibling in her bed, and he fell asleep near the wall, after playing with her phone. The mother then breastfed the subject child in her queen-sized bed, while he laid on his back with his head tilted to the side. The mother reported she did not know if she or the subject child fell asleep first, but believed the subject child fell asleep first while still breastfeeding. The mother woke up at approximately 12:30AM and breastfed the subject child again. At approximately 4:00AM, the mother woke up facing away from the subject child and when she turned, reported the subject child appeared lifeless and his onesie was damp with breast milk. The mother attempted rescue breaths and screamed for the maternal grandmother. The mother brought the subject child to the grandmother, who attempted CPR and called 911. The record reflected that MCDSS was aware the mother was prescribed Suboxone; however, does not reflect that MCDSS had further discussion with the mother regarding medication use. In the mother's statement to law enforcement, she reported she is prescribed Suboxone and is supposed to take it three times a day; however, on 3/31/22, she "ran herself short" and only took it twice. The record does not reflect the mother was questioned regarding her use of Suboxone.

The grandmother corroborated the mother's recollection of events and added that she got up to use the bathroom around 2:00AM and looked into the mother's bedroom. The grandmother observed the mother asleep on the edge of the bed with her back to the subject child, who was sleeping on his back. The grandmother noted there was space between the mother and subject child, and that the sibling was asleep facing the wall away from the subject child. The sibling remained upstairs in the bedroom after the mother awoke and brought the subject child downstairs to the grandmother. MCDSS attempted to interview the sibling; however, an interview could not be completed due to the sibling's age and development.

MCDSS spoke on the phone with the father of the surviving sibling who stated that he had some concerns for the mother's drug use as she had told him that she was on Suboxone and that she was put on a generic RX when she became pregnant. A week later, during the home visit with this father, no further questions were asked regarding the mother's history of substance misuse or current use of suboxone.

MCDSS made multiple phone calls to the mother's substance use treatment providers and left messages; however, the record does not reflect that collateral information was obtained from those providers pertaining to the mother's current treatment.

MCDSS conducted a home visit in response to the subject child's death and observed multiple safe sleep provisions for the subject child including a bassinet and Pack n' Play. The subject child and the sibling shared a room, where the sibling also had appropriate sleep accommodations; however, the mother and grandmother both reported the mother regularly co-slept with the children in her bed.

MCDSS spoke with the children's pediatrician, who noted no medical concerns for the subject child or the sibling. The father of the sibling and the paternal grandmother were interviewed and expressed concern about how the subject child's death would affect the mother. The father of the subject child was unable to be located or interviewed throughout the investigation, despite diligent efforts by MCDSS. The surviving sibling was observed on multiple home visits and deemed to be safe.

Official Manner and Cause of Death

Official Manner: Accident

Primary Cause of Death: From an injury - external cause

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Comments: MCDSS coordinated efforts with Law Enforcement and notified the DA's office of the subject child's death.

Was the fatality referred to an OCFS approved Child Fatality Review Team? No

Comments: Montgomery 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
060897 - Deceased Child, Male, 30 Days	060917 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
060897 - Deceased Child, Male, 30 Days	060917 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
060897 - Deceased Child, Male, 30 Days	060919 - Grandparent, Female, 43 Year(s)	Inadequate Guardianship	Unsubstantiated
060897 - Deceased Child, Male, 30 Days	060919 - Grandparent, Female, 43 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
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:

MCDSS made diligent efforts to locate the father of the subject child; however, were unsuccessful. Written notice of the report was sent to the father's last known address. MCDSS was unable to interview the 3yo sibling due to his development and age.

Fatality Safety Assessment Activities

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

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

Explain:

The record does not reflect that key information was obtained from the mother pertaining to her medication use to further assess the sibling's safety.

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

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

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐

Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The mother had previously been engaged with a domestic violence advocate due to the allegations from the report open at the time of the subject child's death. The pediatrician completed an Early Intervention referral for the 3-year-old sibling. The mother and maternal grandmother were also engaged with substance misuse counseling prior to the fatality, due to a history of substance misuse.

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:
There was no need for services identified for the sibling, due to his age and lack of understanding regarding the subject child's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDSS offered bereavement and counseling services to the mother and maternal grandmother. During the investigation, the grandmother began counseling services through a previously established service provider; however, at the time of case closure, the mother stated she was not ready to engage in 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? 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)
06/10/2021	Sibling, Male, 2 Years	Father, Male, 22 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
The SCR report alleged the mother and father of the subject child got into a verbal argument on 6/8/21. The mother was holding the sibling when the father pushed them against a wall, and the sibling began to cry as a result.

Report Determination: Indicated | **Date of Determination:** 05/03/2022

Basis for Determination:
MCDSS determined there was credible evidence to substantiate the allegations. The investigation determined there was an argument between the mother and father of the subject child. The father pushed the mother, and the mother filed for a Stay Away Order of Protection against the father for herself and the sibling. During the investigation, MCDSS assessed the home, contacted collaterals, and interviewed the father of the sibling.

OCFS Review Results:
MCDSS initiated their investigation by contacting the source of the report. MCDSS assessed all households and interviewed all adults pertaining to the allegations of the report. There was no documented casework activity between 7/26/21 and 3/31/22, until after the subject child's death was reported. The case record does not reflect that safe sleep practices were discussed with the mother, or that Risk Assessment questions were discussed with the father of the subject child.

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 any casework activity from 7/26/21 to 3/31/22, when a subsequent report was received pertaining to the subject child's death.

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

Action:

MCDSS 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, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

PIP Requirement:

There is no required action for this citation, as MCDSS already has a citation in place to address timeliness of investigation determinations.

Issue:

Failure to provide safe sleep education/information

Summary:

There is no documentation that MCDSS reviewed safe sleep practices with the mother or observed safe sleep provisions for the subject child, who was born during the investigation.

Legal Reference:

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

Action:

MCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

PIP Requirement:

The Albany Regional Office informed OCFS there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. MCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

Conversations with the father of the subject child lacked key safety-related questions pertaining to domestic violence, the mother and father's relationship, and the safety of the children, despite the father being the subject of the report.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

Prior to making a determination, MCDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/23/2019	Sibling, Male, 6 Days	Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes

Report Summary:

The SCR report alleged the mother gave birth to the surviving sibling and the sibling's meconium was submitted for drug screening testing, which came back positive for marijuana. The maternal grandmother and 16-year-old maternal aunt lived in the home with the mother. The father to the sibling lived in a separate residence and had an unknown role. The mother's drug test was negative for all substances.

Report Determination: Indicated | **Date of Determination:** 06/11/2019

Basis for Determination:

MCDSS found there was credible evidence to substantiate the allegation of PD/AM against the mother due to the

sibling's meconium being positive for marijuana. MCDSS interviewed the subjects of the report, family members, personal and professional collaterals, and observed the sibling. The mother reported to hospital staff that she stopped using substances when she found out she was pregnant. Both the mother and sibling's urine screens were negative. The child was deemed safe and the investigation was closed.

OCFS Review Results:
MCDSS initiated their investigation within 24-hours, interviewed the alleged subjects and household members, and contacted collateral sources. MCDSS documented progress notes timely and notified all adults of the report in writing. The case record does not reflect a Plan of Safe Care being completed, despite the sibling having a positive toxicology for marijuana at birth and the subsequent indication of the investigation. MCDSS indicated the mother for PD/AM; however, there was no documentation that the positive toxicology had a negative effect on the child.

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

Issue:
Appropriateness of allegation determination

Summary:
MCDSS indicated the allegation of PD/AM against the mother due to the sibling having a positive toxicology for marijuana at birth; however, the record did not reflect that there was a negative impact on the child.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
MCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Albany Regional Office if further guidance is needed.

PIP Requirement:
The Albany Regional Office informed OCFS there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. MCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

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

Summary:
There is no documentation that a Plan of Safe Care was created, despite the sibling having a positive toxicology at birth.

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

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

PIP Requirement:
There is no required action for this citation as guidance surrounding the Plan of Safe Care was modified after the close of this investigation.

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

Between 2002 and 2017, there were two unfounded investigations and one indicated investigation. The investigations all

included the maternal grandmother as the alleged subject with allegations of IG, LMED and PD/AM. The indicated investigation from 2002 was due to the maternal grandmother not providing proof of medical care for a maternal aunt.

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.

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