Child Fatality Report

Report Identification Number: SY-22-022

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

Issue Date: Oct 31, 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 10 month(s)
Jurisdiction: Broome
Gender: Female
Date of Death: 05/05/2022
Initial Date OCFS Notified: 05/05/2022

Presenting Information

An SCR report alleged that at midnight on 5/4/22, the father changed the subject child's diaper and placed her on a small couch in the parents' bedroom. The subject child was on the couch with a pillow and blanket. When the parents awoke on 5/5/22, the pillow and blanket were covering the subject child's face. The subject child was unresponsive and the parents called 911. The subject child's position on the couch was unknown. Emergency medical services responded to the home and the subject child was transported to a local hospital where she was pronounced deceased. The subject child was otherwise healthy and the parents had no explanation for her death. It was unknown if the subject child had any physical injuries to her body. A subsequent SCR report was received on 5/5/22, with concerns regarding the condition of the home and alleging the father laid on the subject child.

Executive Summary

This fatality report concerns the death of a 10-month-old female subject child that occurred on 5/5/22. The SCR report contained allegations of DOA/Fatality against the mother and father, as well as allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter against the mother, father, mother of the 2-year-old cousin, and 20-year-old maternal uncle. At the time of the subject child's death, she and her parents resided in the home of the 20-year-old maternal uncle along with the uncle’s 2-year-old son (cousin to the subject child) and a 10-year-old maternal uncle. The mother of the 2-year-old cousin lived in a nearby apartment.

Broome County Department of Social Services (BCDSS) completed collateral and casework contacts and learned that around midnight on 5/5/22, the father changed the subject child’s diaper and laid her next to him until she fell asleep. The father then moved the subject child to a couch located in the same room. The father put a pillow under the subject child’s head and used a t-shirt as a blanket to cover the child. At approximately 7:00AM, the parents awoke and observed that the subject child was unresponsive. The father reported that when they found the subject child, the t-shirt and pillow were covering her nose and face. The father called 911 and began cardiopulmonary resuscitation. Emergency medical services arrived and transported the subject child to the hospital, where she was later pronounced deceased.

An autopsy was performed, and the final cause and manner of death were pending at the time of this writing. Law enforcement noted that the subject child had a low PH, a high white blood cell count, and very high blood sugar at the time of her death. There have been no criminal charges filed pertaining to the subject child’s death.

The family was offered bereavement services following the subject child’s death. The mother and father moved out of the maternal uncle’s residence. The mother of the 2-year-old cousin moved in with the maternal uncle and there were on-going concerns regarding the condition of the home, which were addressed by implementing in-home community-based services. The 10-year-old maternal uncle moved in with his parents, the maternal grandparents of the subject child. The case remained open at the time of this writing pending the final autopsy report.

PIP Requirement
This review resulted in a citation related to casework practice. In response, BCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the BCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, BCDSS 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?** Yes
  - **Safety assessment due at the time of determination?** N/A
- **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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The case remained open at the time of this writing; therefore, no Safety Assessment had been completed and no determination was made.

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:
Casework activity was not commensurate with case circumstances, as the record did not reflect that BCDSS had follow up conversations with the MGM and 10yo MU when additional information was received alleging the 10yo MU had contact with the SC during the time she was suspected to have died.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	BCDSS learned through a statement from the MGM that the 10yo MU may have been the last to see the SC during the time she was suspected to have died, despite the 10yo MU reporting to CPS that he was asleep during the incident and did not know what occurred until the mother of the 2yo cousin woke him up. The record did not reflect that BCDSS explored this discrepancy further with the family.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	BCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/05/2022 **Time of Death:** Unknown

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

County where fatality incident occurred: Broome
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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

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	Aunt/Uncle	Alleged Victim	Male	10 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Male	20 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	10 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Other Adult - Mother of Other Child	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Other Child - Cousin	Alleged Victim	Male	2 Year(s)
Other Household 1	Grandparent	No Role	Female	45 Year(s)
Other Household 1	Grandparent	No Role	Male	43 Year(s)

LDSS Response

Upon receipt of the SCR report, BCDSS coordinated their investigation with law enforcement, notified the district attorney's office, spoke with collateral sources, and interviewed household members.

BCDSS interviewed the SM and SF on 5/5/22 and learned that the SF changed the SC's diaper and laid her down next to

him on the adult-sized bed, though the SM and SF had discrepancies about the time of these events. The SM reported around the time the SC was laid down, she observed the SF with his arm over the SC. The SM felt the SF was putting too much pressure on the SC and moved his arm. The SF moved the SC to the couch, where he put a pillow under the SC's head and covered her with a t-shirt, as a blanket. The SF woke up around 7:00AM and found the SC face-up and not breathing with the t-shirt over her face. Though law enforcement reported the SM observed the SC face-down on the couch, there was no documentation that this inconsistency was clarified. The SF stated the SC could not hold her head up and her lips were the color of her skin. The SF called 911 and initiated CPR. The SC was transported to the hospital where she was later pronounced deceased.

The 20yo MU reported that he returned home from work around 12:20AM on 5/5/22, and went to sleep until the SM and SF woke him to inform him about the condition of the SC. The 20yo MU also reported calling 911 and told the mother of the 2yo cousin to come to the residence at that time. The 10yo MU reported that the last time he saw the SC was between 1:00AM and 2:00AM when she was awake and playing on the parents' bed. The 10yo MU stated that he was asleep during the incident and did not see EMS or law enforcement at the home, and was woken up by the mother of the 2yo cousin after the incident occurred. The MGM later reported that the 10yo MU heard the SC crying around 5:00AM and put the SC back to sleep. Despite receiving this information, the record does not reflect that this information was further explored with the MGM, 10yo MU, or the other adults.

The parents reported that they had recently been evicted from their home and had been staying at the 20yo MU's residence for approximately one week and therefore did not have safe sleep accommodations at the new residence. The SF reported the SC normally slept in a portable crib at their previous residence; however, co-slept with the parents or slept on the couch since moving.

BCDSS learned that the SC was born with a positive toxicology for marijuana. The SC had history of a respiratory diagnosis when she was 4 months old, which was reportedly treated. The SC had a doctor appointment scheduled for 4/10/22, that the SM reported was missed due to transportation issues. Hospital staff noted that if the SC's death was related to an underlying medical condition, it may have been caught at this appointment. The SC was last seen 1/6/22, and the pediatrician noted no concerns.

There were on-going concerns regarding the condition of the 20yo MU's home and the impact this had on the 2yo cousin's safety. The home was observed on numerous home visits to have animal feces and garbage. The 20yo MU and the mother of the 2yo cousin were offered in-home community-based services to address these concerns, which were accepted. Services were on-going at the time of this writing and the 2yo was deemed safe.

Official Manner and Cause of Death

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

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
Comments: Broome County Department of Social Services referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061610 - Deceased Child, Female, 10 Mons	061612 - Other Adult - Mother of Other Child, Female, 20 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061610 - Deceased Child, Female, 10 Mons	061616 - Aunt/Uncle, Male, 20 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061610 - Deceased Child, Female, 10 Mons	061616 - Aunt/Uncle, Male, 20 Year(s)	Inadequate Guardianship	Pending
061610 - Deceased Child, Female, 10 Mons	061612 - Other Adult - Mother of Other Child, Female, 20 Year(s)	Inadequate Guardianship	Pending
061610 - Deceased Child, Female, 10 Mons	061615 - Father, Male, 22 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061610 - Deceased Child, Female, 10 Mons	061613 - Mother, Female, 19 Year(s)	DOA / Fatality	Pending
061610 - Deceased Child, Female, 10 Mons	061613 - Mother, Female, 19 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061610 - Deceased Child, Female, 10 Mons	061615 - Father, Male, 22 Year(s)	DOA / Fatality	Pending
061610 - Deceased Child, Female, 10 Mons	061615 - Father, Male, 22 Year(s)	Inadequate Guardianship	Pending
061610 - Deceased Child, Female, 10 Mons	061613 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Pending
061617 - Aunt/Uncle, Male, 10 Year(s)	061615 - Father, Male, 22 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061617 - Aunt/Uncle, Male, 10 Year(s)	061616 - Aunt/Uncle, Male, 20 Year(s)	Inadequate Guardianship	Pending
061617 - Aunt/Uncle, Male, 10 Year(s)	061616 - Aunt/Uncle, Male, 20 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061617 - Aunt/Uncle, Male, 10 Year(s)	061613 - Mother, Female, 19 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061617 - Aunt/Uncle, Male, 10 Year(s)	061612 - Other Adult - Mother of Other Child, Female, 20 Year(s)	Inadequate Guardianship	Pending
061617 - Aunt/Uncle, Male, 10 Year(s)	061612 - Other Adult - Mother of Other Child, Female, 20 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061617 - Aunt/Uncle, Male, 10 Year(s)	061613 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Pending
061617 - Aunt/Uncle, Male, 10 Year(s)	061615 - Father, Male, 22 Year(s)	Inadequate Guardianship	Pending
061618 - Other Child - Cousin, Male, 2 Year(s)	061616 - Aunt/Uncle, Male, 20 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061618 - Other Child - Cousin, Male, 2 Year(s)	061613 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Pending
061618 - Other Child - Cousin, Male, 2 Year(s)	061615 - Father, Male, 22 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061618 - Other Child - Cousin, Male, 2 Year(s)	061613 - Mother, Female, 19 Year(s)	Inadequate Food / Clothing / Shelter	Pending

061618 - Other Child - Cousin, Male, 2 Year(s)	061612 - Other Adult - Mother of Other Child, Female, 20 Year(s)	Inadequate Guardianship	Pending
061618 - Other Child - Cousin, Male, 2 Year(s)	061612 - Other Adult - Mother of Other Child, Female, 20 Year(s)	Inadequate Food / Clothing / Shelter	Pending
061618 - Other Child - Cousin, Male, 2 Year(s)	061615 - Father, Male, 22 Year(s)	Inadequate Guardianship	Pending
061618 - Other Child - Cousin, Male, 2 Year(s)	061616 - Aunt/Uncle, Male, 20 Year(s)	Inadequate Guardianship	Pending

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:

Broome County requested a reenactment be completed pertaining to the subject child's death; however, the parents refused.

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:
The Risk Assessment Profile had not been completed at the time of this writing, as the investigation remained open.

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: In-Home Community Based Services							
Additional information, if necessary: The 20yo MU and the mother of the 2yo cousin are engaged with in-home community based services.							

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:
Grief resources were provided on behalf of the 10-year-old MU.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement and mental health services were offered to all adults following the subject child's death.

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?	N/A
Was the child acutely ill during the two weeks before death?	Yes

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/28/2021	Aunt/Uncle, Male, 10 Years	Grandparent, Female, 44 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Aunt/Uncle, Male, 10 Years	Grandparent, Female, 44 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Cousin, Male, 2 Years	Grandparent, Female, 44 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Cousin, Male, 2 Years	Grandparent, Female, 44 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 3 Months	Grandparent, Female, 44 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 3 Months	Grandparent, Female, 44 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Aunt/Uncle, Male, 10 Years	Mother, Female, 18 Years	Inadequate Guardianship	Unsubstantiated	
	Aunt/Uncle, Male, 10 Years	Mother, Female, 18 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Cousin, Male, 2 Years	Mother, Female, 18 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Cousin, Male, 2 Years	Mother, Female, 18 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 3 Months	Mother, Female, 18 Years	Inadequate Guardianship	Unsubstantiated	

Deceased Child, Female, 3 Months	Mother, Female, 18 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - Cousin, Male, 2 Years	Other Adult - Mother of Other Child, Female, 20 Years	Lack of Medical Care	Substantiated

Report Summary:
The SCR report alleged that the mother of the SC smoked marijuana in the home while in the presence of the 10yo MU, 2yo cousin, and then 3-month-old SC. The home and children smelled like marijuana. The home was filthy and both the mother of the SC and mother of the 2yo cousin failed to clean the home, which had garbage, debris, old food, dirty dishes, and animal urine and feces on the floor. The house smelled of a foul odor and was infested with roaches and bed bugs.

Report Determination: Indicated **Date of Determination:** 11/08/2021

Basis for Determination:
BCDSS determined there was credible evidence to substantiate the allegation of LMC against the mother of the 2yo cousin, which was added during the course of the investigation. The SC tested positive for a respiratory virus. The 2yo cousin appeared dirty, with no shoes or coat on while the weather was cool, and also had a very bad cough. BCDSS advised the mother of the 2yo cousin multiple times to take the 2yo to be seen by a doctor. The mother never took the child to the doctor during the case and reported the child was feeling better. This placed the 2yo at risk of harm due to his age and the risk associated with respiratory virus. BCDSS did not document the children smelled of marijuana; however, they did note there was an odor and clutter in the home, but no visible safety concerns.

OCFS Review Results:
BCDSS initiated their investigation within 24-hours, reviewed the family's CPS history, and attempted to interview household members. BCDSS contacted collateral sources throughout the investigation. At the initial home visit, there was concern regarding the MGM misusing substances and though the MGM would not speak with BCDSS, this concern was not addressed with the other adults in the home to fully assess the safety of the children. The 10 and 15yo MU's were not interviewed regarding the allegations of the report or about risk assessment questions. Additional information was received regarding the 10yo uncle bringing marijuana to school, which resulted in him being suspended; however, this was not addressed with the 10yo or his parents.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
Upon initial contact, BCDSS noted possible substance misuse by the MGM due to her behavior and appearance. Although the MGM refused to talk to BCDSS, this concern was not addressed with the other adults in the home to determine the impact on the safety of the children residing there. Additional information was received that the 10yo MU brought marijuana to school, but it was not documented that this was addressed with the 10yo or his parents.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
BCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
The record did not reflect that the 10yo MU and the now 15yo MU were interviewed regarding the allegations of the report or about questions pertaining to risk assessment, despite the SCR report naming the MGM as a subject of the report and the 10yo MU as maltreated. There was no documentation of face-to-face contact with the father of the SC.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

BCDSS will make 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/28/2020	Other Child - Cousin, Male, 9 Months	Other Adult - Mother of Other Child, Female, 18 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Cousin, Male, 9 Months	Other Adult - Mother of Other Child, Female, 18 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Other Child - Cousin, Male, 9 Months	Other Adult - Mother of Other Child, Female, 18 Years	Lack of Supervision	Unsubstantiated	

Report Summary:

An SCR report alleged that on 4/28/22, the mother of the now 2yo cousin was not providing adequate supervision and was on the phone while the cousin sat on the windowsill. As a result, the cousin fell and sustained bruises, and a mark to the forehead. It was unknown if this was an isolated incident.

Report Determination: Unfounded

Date of Determination: 11/16/2020

Basis for Determination:

BCDSS determined there was not enough credible evidence to substantiate the allegations against the mother. The now 2yo cousin fell and hit his head while trying to hold himself up by a window. The cousin did have a bruise, but the cousin's doctor expressed no concerns.

OCFS Review Results:

BCDSS initiated their investigation within 24-hours, contacted the source of the report, conducted a home visit, and assessed the safety of the 2yo cousin. BCDSS interviewed all household members face-to-face, when appropriate. BCDSS contacted collateral sources and reviewed safe sleep with the mother of the now 2yo cousin. The CPS history check was completed late, on 10/28/20. There was no casework activity from 5/6/20 to 9/16/20.

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

Issue:

Review of CPS History

Summary:

The CPS history check was completed late, on 10/28/20.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

After the initial home visit on 4/29/20 in which BCDSS observed a mark to the now 2yo cousin's head, BCDSS did not continually assess his safety throughout the investigation. There was no documented casework between 5/6/20 and 9/16/20. The now 2yo cousin sustained an injury while in the mother's care and was not seen again until 11/3/20.

Legal Reference:

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

Action:

BCDSS will prioritize making an adequate assessment of safety and risk to all children in the household and continue an on-going assessment of safety and risk throughout the length of the investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/15/2020	Other Child - Cousin, Male, 5 Months	Aunt/Uncle, Male, 17 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Cousin, Male, 5 Months	Aunt/Uncle, Male, 17 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Cousin, Male, 5 Months	Other Adult - Mother of Other Child, Female, 17 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Cousin, Male, 5 Months	Other Adult - Mother of Other Child, Female, 17 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

An SCR report alleged that the mother of the now 2yo cousin and 20yo MU abused marijuana to the point of impairment while caring for the now 2yo cousin, left him on the bed and watched him roll off. The mother of the now 2yo cousin abused heroin two months prior and continued breastfeeding the now 2yo cousin with intent to make him fall asleep faster. The mother of the now 2yo cousin and the 20yo MU engaged in verbal and physical altercations in the presence of the now 2yo cousin. The 20yo MU became physically aggressive toward the now 2yo cousin and smacked him, threw objects at him, and shook him when he cried. The now 2yo cousin sustained handprint marks on his back due to being smacked.

Report Determination: Unfounded | **Date of Determination:** 03/17/2020

Basis for Determination:

BCDSS determined there was no credible evidence to substantiate the allegations against the mother of the now 2yo cousin and the 20yo MU. The family was minimally cooperative with the investigation; however, there was no evidence of marijuana use to the point of impairment while being sole caretakers or that physical and verbal altercations occurred in the presence of the now 2yo old cousin. Although not documented in the investigation conclusion, it is reflected in the case record that the mother of the 2yo cousin denied the allegation that the 20yo uncle shook the child, and household members denied physical aggression toward the children in the home.

OCFS Review Results:

BCDSS initiated their investigation within 24 hours and contacted the source of the report. BCDSS attempted a home visit; however, the family was minimally cooperative and would not allow BCDSS into the home. The record did not reflect that safety was assessed or there was an attempt to interview the now 15yo MU. BCDSS made a safety plan with the mother of the now 2yo cousin, that she and the 2yo cousin would reside with her mother due to concerns regarding substance use in the MU's home. Additional information was received that this plan was no longer being followed; however, there was no documentation that BCDSS further discussed this. Although the record does not say if BCDSS observed the child's back to look for a mark, BCDSS does note the child was free of suspicious marks/bruises.

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

Issue:

Review of CPS History

Summary:

The CPS history check was completed late, on 3/4/20.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

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

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

5 out of 12 progress notes were completed over 30 days after the 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:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

There was no documentation that the safety of the now 15yo uncle was assessed, despite him living in the home with the subject parents. BCDSS implemented a safety plan for the mother of the now 2yo cousin to reside with her mother due to concerns of substance misuse in the MU's home and learned that this plan was not being followed; however, the record did not reflect that this was further explored. The 20yo MU was interviewed on risk assessment questions, but there was no documentation that he was interviewed pertaining to the allegations that he shook, smacked and threw things are the 2yo cousin.

Legal Reference:

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

Action:

BCDSS will prioritize making an adequate assessment of safety and risk to all children in the household and continue an on-going assessment of safety and risk throughout the length of the investigation.

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 CPS history outside of New York State.

Preventive Services History

The 10yo MU received preventive services from 3/2018 to 4/2019 due a lack of supervision and educational concerns for the MGM's children, and again from 3/2020 to 3/2021 due to behavioral concern for the 15yo MU.

Foster Care Placement History

The 10yo MU was removed from the MGM and MGF's care in 6/2015 due to the MGM and MGF's substance misuse and concerns regarding the condition of the home. The 10yo MU was placed with a relative until he was returned to the MGM and MGF's care in 4/2016 when services were completed.

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

The statement made is that there are no follow up conversations with the ten year old or maternal grandmother about contact they may have had with infant. BCDSS was awaiting the findings of the autopsy report to see if there was additional information in order to further interview the 10 year old and grandmother. Upon receipt of the autopsy report the cause of death was still listed as Undetermined. Law enforcement was not doing any follow up based on no further information. BCDSS tries to do trauma informed practice. We do not interview children particularly regarding infant deaths unless there is a best interests reason to do so as interviewing children over and over causes increasing trauma. (and the same is true for adults).

On the previous report dated 9/28/21, concerns were noted that the an Add Info was received about the 10 year old being suspended from school for bringing marijuana to school and this was not addressed. The CW did speak to school, law enforcement, and the subject about the issue.

It was also noted that the grandmother showed signs of possible substance misuse. The CW went to legal and ensured an access order was asked for in the event that the family did not cooperate, which they eventually did.

The 1/15/20 report indicates that the 15 year child is not spoken to, however, there is a preventive case open for PINs on the 15 year old that is kept open from 3/20 until 3/21.

The other issues on the previous cases such as late history checks and progress notes not being put in contemporaneously are acknowledged. CWs have these issues addressed in their policy manual and at their division meetings.

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