Child Fatality Report

Report Identification Number: SV-23-021

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

Issue Date: Sep 26, 2023

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 had an open investigation or a CPS monitored services 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
Jurisdiction: Sullivan
Date of Death: 05/02/2023
Age: 1 year(s)
Gender: Female
Initial Date OCFS Notified: 05/03/2023

Presenting Information

An SCR report alleged that on 5/2/23 at approximately 6:30 PM, the mother and the father were impaired on unknown drugs while caring for the 1-year-old subject child and 3-month-old sibling. The mother left the motel room and the father fell asleep, leaving the drugs accessible to the children. As a result, the child was able to access and ingest fentanyl and overdosed. The child was found by the mother on the bedroom floor deceased. The sibling was found in a car seat on the bed. The mother ran into the hallway screaming, and the motel manager called 911. Law enforcement arrived at 7:30 PM. The children were taken to the hospital. The mother and father had a history of using drugs to the point of impairment in the presence of and while caring for the children. On 5/4/23, a duplicate report was received which alleged the same concerns.

Executive Summary

On 5/3/23, the Sullivan County Department of Family Services (SCDFS) received an SCR report regarding the death of the 1-year-old female subject child. The report contained allegations of DOA/Fatality, Inadequate Guardianship, Lack of Supervision, Parent Drug/Alcohol Misuse, and Poisoning/Noxious Substances against the parents. The child resided with the mother, father, and 3-month-old sibling in motel housing provided by SCDFS. The parents were arrested and the surviving sibling was placed in foster care as a result of the fatality. The mother had a child who was removed from her care in 2018 and that child lived with her father.

On 5/2/23, the subject child was at the motel with her parents, sibling and maternal grandmother. The parents and grandmother smoked crack cocaine in the presence of the children. After smoking, the mother left the motel to get more drugs. The grandmother left afterward, leaving the children with the father. The father continued to use drugs and passed out. The mother returned to the motel room and found the subject child on the floor. The child was unresponsive and in full cardiac respiratory arrest. The mother picked up the child, took her to the motel lobby, and staff at the motel contacted 911. First responders arrived and administered life-saving efforts. The child was transported to the hospital where efforts continued until the child was pronounced deceased at 8:58 PM.

An autopsy was conducted and the child's cause of death was acute drug intoxication including fentanyl, para-fluorofentanyl, and xylazine and the manner was accidental. Law enforcement investigated the death and the parents were charged with manslaughter in the second degree and the grandmother was charged with endangering the welfare of a child. The parents were incarcerated pending the trial related to their charges.

SCDFS conducted an emergency removal of the sibling on 5/3/23 and he was placed in foster care. Neglect petitions were filed against the parents and the removal was upheld in family court. The sibling was assessed to be safe in the care of the foster parents. The allegations against the parents were substantiated, as they admitted to using fentanyl while caring for the children. The parents left the drug accessible to the children, resulting in the child ingesting it and dying. The CPS investigation was indicated and closed on 7/2/23 and the foster care case remained open.

A review of the historical child protective cases and preventive services cases revealed that the parents used illicit substances preceding and since their involvement with SCDFS. The subject child and sibling were born with a positive toxicology for drugs and the parents admitted to drug use. The parents were offered services, including a public health

nurse, preventive services, and housing services. The parents were generally non-compliant with service providers. Despite the services provided and offered, the parents continued to test positive for illicit substances at their substance abuse treatment program. Between 2021 and 2023, the casework activity that was documented by SCDFS was inconsistent in addressing safety concerns. SCDFS reported to the Westchester Regional Office that they conferenced with their legal department on three occasions, 1/23/23, 2/6/23, and 2/24/23, and were unable to move forward with the removal of the children following those conferences.

PIP Requirement

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

Explain:
n/a

Determination:

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

Explain:
The determination was appropriate and supported by the information in the case record.

Was the decision to close the case appropriate?	N/A
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	Yes
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:
The CPS investigation was indicated and closed on 7/2/23. A foster care case remained open.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/02/2023 **Time of Death:** 08:58 PM

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

County where fatality incident occurred: Sullivan
Was 911 or local emergency number called? Yes
Time of Call: 07:32 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Yes
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	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	41 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Month(s)

LDSS Response

Upon receipt of the SCR reports, SCDFS contacted the sources, completed a visit to the motel, contacted collaterals, and completed a removal of the surviving sibling. The record did not indicate joint interviews of the parents were conducted with law enforcement, but SCDSS documented contacts with law enforcement to request information from them.

The parents were incarcerated following the fatality and their attorneys would not allow SCDFS to interview them regarding the allegations. Law enforcement interviewed the parents. SCDFS requested the interview transcripts on 6/23/23; however, they were not received when the investigation was closed on 7/2/23. The criminal proceedings were ongoing. The parents were present during family court proceedings in which the allegations were discussed and they both denied them.

The sibling was too young to be interviewed. SCDFS removed the sibling from the parents' care and he was placed in a foster home. The sibling had a medical exam due to the child's death and the results were negative for any substances and fractures. The sibling had a diaper rash, a cough, and scratches on his forehead. Medical records showed that the sibling was referred to an otolaryngologist while in the care of the parents and three scheduled appointments were missed. The foster parent reported an appointment was made for 5/23/23. The sibling's weight had improved since his placement in foster care. According to the foster parent, they brought the sibling to an osteopath for reflux. The osteopath said that it was obvious that the sibling had been left either lying or sitting for long periods of time without being picked up because of the way his muscles had formed. It was reported the sibling had been left to sit in the car seat for hours at a time. The osteopath also said the sibling had been picked up or pulled by his left arm a lot, evidenced by the condition of his shoulder.

SCDFS documented sporadic contact with the parents' substance abuse treatment program since the family's involvement with child protective services. During the investigations that began on 12/26/21 and 5/3/22, SCDFS retrieved updates on the parents' status in their treatment, which revealed concerns about drug use. During the investigation beginning on 1/12/23, SCDFS documented attempts to gather information regarding the parents' drug use and were refused the information by the treatment provider, despite a release of information completed by the parents. During the 3/20/23 investigation, SCDFS documented multiple attempted phone calls without any success. Following the fatality, SCDFS spoke to the substance abuse treatment providers and retrieved records. It was learned that the father began treatment in August 2021 and the mother in September 2020. The parents were supposed to be in receipt of monthly drug screens; however, there were times when they refused to provide a sample, or the samples were tampered with. Several drug screens were positive for fentanyl, methadone, and cocaine. Their attendance was not consistent and the father was refusing recommendations made by his counselor. The program was aware of the parents' involvement with child protective services. Records indicated serious concerns for the safety of the children; however, at the time that was noted, SCDFS documented several attempted contacts to the program without any returned calls.

The sibling was assessed at the foster home during the investigation. Services were being provided to the sibling through the foster care case. The parents were incarcerated and SCDFS reported that they were offered services regarding the fatality at the jail. Family members were attempting to gain custody of the sibling, and those resources were being explored through ongoing family court proceedings.

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

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

Comments: Sullivan 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
064781 - Deceased Child, Female, 1 Yrs	064789 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
064781 - Deceased Child, Female, 1 Yrs	064789 - Mother, Female, 26 Year(s)	Lack of Supervision	Substantiated
064781 - Deceased Child, Female, 1 Yrs	064789 - Mother, Female, 26 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
064781 - Deceased Child, Female, 1 Yrs	064790 - Father, Male, 41 Year(s)	Inadequate Guardianship	Substantiated
064781 - Deceased Child, Female, 1 Yrs	064790 - Father, Male, 41 Year(s)	Lack of Supervision	Substantiated
064781 - Deceased Child, Female, 1 Yrs	064790 - Father, Male, 41 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
064781 - Deceased Child, Female, 1 Yrs	064789 - Mother, Female, 26 Year(s)	DOA / Fatality	Substantiated
064781 - Deceased Child, Female, 1 Yrs	064789 - Mother, Female, 26 Year(s)	Poisoning / Noxious Substances	Substantiated
064781 - Deceased Child, Female, 1 Yrs	064790 - Father, Male, 41 Year(s)	DOA / Fatality	Substantiated
064781 - Deceased Child, Female, 1 Yrs	064790 - Father, Male, 41 Year(s)	Poisoning / Noxious Substances	Substantiated
064788 - Sibling, Male, 3 Month(s)	064789 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
064788 - Sibling, Male, 3 Month(s)	064789 - Mother, Female, 26 Year(s)	Lack of Supervision	Substantiated
064788 - Sibling, Male, 3 Month(s)	064789 - Mother, Female, 26 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
064788 - Sibling, Male, 3 Month(s)	064790 - Father, Male, 41 Year(s)	Inadequate Guardianship	Substantiated
064788 - Sibling, Male, 3 Month(s)	064790 - Father, Male, 41 Year(s)	Lack of Supervision	Substantiated
064788 - Sibling, Male, 3 Month(s)	064790 - Father, Male, 41 Year(s)	Parents Drug / Alcohol Misuse	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 maternal grandmother was present on the day of the death and the record did not reflect attempts to interview her. The parents were incarcerated and their attorneys refused to allow SCDFS to interview them.

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?	☒	☐	☐	☐

Explain:
There were ongoing safety issues for the children due to the parents' drug use.

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:
Mental health services, bereavement counseling, and assistance with funeral arrangements were not directly provided by SCDFS due to the parents' incarceration; however, SCDFS reported these services were offered by the jail.

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 as a result of information uncovered during the fatality investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
An emergency removal of the sibling was conducted on 5/3/23. On 5/5/23, the removal was upheld in family court.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☒Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/04/2023	There was not a fact finding	Foster Care Placement to Continue
Respondent:	064789 Mother Female 26 Year(s)	
Comments:	On 5/3/23, SCDFS conducted an emergency removal of the sibling. On 5/4/23, neglect petitions were filed against the parents. A first appearance regarding the petitions occurred on 5/5/23 and the judge upheld the removal.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/04/2023	There was not a fact finding	Foster Care Placement to Continue
Respondent:	064790 Father Male 41 Year(s)	
Comments:	On 5/3/23, SCDFS conducted an emergency removal of the sibling. On 5/4/23, neglect petitions were filed against the parents. A first appearance regarding the petitions occurred on 5/5/23 and the judge upheld the removal.	

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
05/03/2023	Grandmother	Pending	Unknown
Comments:	The grandmother was charged with endangering the welfare of a child.		

Criminal Charge: Manslaughter **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
05/03/2023	Mother	Pending	Unknown
Comments:	As a result of the child's death, the mother was charged with manslaughter in the second degree.		

Criminal Charge: Manslaughter **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
05/03/2023	Father	Pending	Unknown
Comments:	As a result of the child's death, the father was charged with manslaughter in the second degree.		

Have any Orders of Protection been issued? Yes	
From: 05/05/2023	**To:** Unknown

Explain:
As a result of the neglect petitions, the judge ordered stay-away orders of protection against the parents in relation to the sibling.

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:
Mental health services, bereavement counseling, and assistance with funeral arrangements were not directly provided by SCDFS due to the parents' incarceration; however, SCDFS reported these services were offered by the jail.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? No

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)
03/20/2023	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Lack of Supervision	Substantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Poisoning / Noxious Substances	Substantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Lack of Supervision	Substantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Poisoning / Noxious Substances	Substantiated	
	Sibling, Male, 2 Months	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Months	Mother, Female, 26 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 2 Months	Mother, Female, 26 Years	Lack of Medical Care	Substantiated	
	Sibling, Male, 2 Months	Mother, Female, 26 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 2 Months	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 2 Months	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Months	Father, Male, 41 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 2 Months	Father, Male, 41 Years	Lack of Medical Care	Substantiated	

Sibling, Male, 2 Months	Father, Male, 41 Years	Lack of Supervision	Substantiated
Sibling, Male, 2 Months	Father, Male, 41 Years	Parents Drug / Alcohol Misuse	Substantiated

Report Summary:
An SCR report alleged that the sibling had green and blue bruises on both of his inner thighs. The explanations provided by the parents were not consistent with the apparent ages of the bruises.

Report Determination: Indicated | **Date of Determination:** 05/19/2023

Basis for Determination:
SCDFS added the allegations of Parent Drug/Alcohol Misuse, Lack of Supervision, Poisoning/Noxious Substances, and Lack of Medical care against the parents. Those allegations, in addition to Inadequate Guardianship, were substantiated. The parents admitted to smoking fentanyl while caring for the children and leaving the drugs accessible to the children. The subject child ingested the fentanyl and died. A report was registered regarding the death. Lack of Medical care was substantiated regarding the parents' delay in obtaining x-rays for the sibling. Lacerations/Bruises/Welts was unsubstantiated, as SCDFS found no evidence that the parents caused the bruising to the sibling's inner thigh.

OCFS Review Results:
SCDFS assisted the family in obtaining medical care for the SS regarding the bruises. SCDFS documented several efforts to speak to the substance abuse treatment provider to no avail. The parents were using the car seat as a sleep space for the SS and admitted to co-sleeping. The SF disregarded the safe sleep guidance and continued to practice unsafe sleep. SCDFS documented several visits and attempted contact with the family. SCDFS discussed the family's noncompliance with the FSS worker and possible court intervention with the family. SCDFS last saw the SC on 5/2/23 and noted no concerns.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/05/2023	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 1 Years	Unrelated Home Member, Male, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 1 Years	Unrelated Home Member, Male, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged that the mother and the father were abusing heroin while caring for the subject child. Two

unrelated home members abused crack while the subject child was in the home and the parents failed to address it. The subject child had a severe rash that covered her entire body. The mother and the father failed to seek medical attention to address it.

Report Determination: Unfounded

Date of Determination: 02/10/2023

Basis for Determination:
SCDFS unsubstantiated the allegations and wrote in their investigation conclusion "Case closed as not able to consolidate. Please see prior report."

OCFS Review Results:
SCDFS documented that they closed the investigation due to the SCR placing the sibling as an alleged subject at the time of report intake and that they were unable to consolidate with the open investigation due to this. This information was inaccurate, as the alleged subjects on the 2/5/23 SCR report were the parents and two unrelated adult home members. SCDFS incorrectly changed one of the unknown unrelated adult home members to the sibling's information on the person list; therefore, making the sibling a subject. If unable to consolidate, SCDFS should have completed a full investigation into the allegations and documented all casework activity before closing the case.

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

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

There was no casework activity documented within the investigation. Although another case was referenced, SCDFS is required to complete tasks in each open unconsolidated investigation.

Legal Reference:

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

Action:

SCDFS will review and adhere to regulations regarding casework practice.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/12/2023	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 1 Years	Father, Male, 41 Years	Lack of Medical Care	Unsubstantiated	

Deceased Child, Female, 1 Years	Father, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Female, 1 Years	Unrelated Home Member, Male, 27 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 1 Years	Unrelated Home Member, Male, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 1 Days	Unrelated Home Member, Male, 27 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 1 Days	Unrelated Home Member, Male, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 1 Days	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 1 Days	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Substantiated

Report Summary:
Between 1/12/23 and 1/31/23, multiple SCR reports were received. The reports alleged that on 1/12/23, the SM gave birth to the 3-month-old SS and the SS tested positive for cocaine. The SS was experiencing withdrawal symptoms and was hospitalized. The parents used heroin and crack while caring for the SC and there was no food in the home. On 2/5/23, an SCR report was received which alleged concerns for drug use by the parents and an unrelated home member. In addition, it alleged concern for a rash covering the SC's body. SCDFS did not correctly consolidate the report with the initial; however, added the allegations from the 2/5/23 report to the initial investigation for determination.

Report Determination: Indicated | **Date of Determination:** 02/24/2023

Basis for Determination:
SCDFS substantiated the allegations of Inadequate Guardianship and Parent's Drug/Alcohol Misuse against the mother. The sibling tested positive for cocaine, fentanyl, methadone, morphine, and benzodiazepines and was hospitalized due to withdrawal symptoms.

OCFS Review Results:
The casework activity was not commensurate with case circumstances and SCDFS did not adequately address safety concerns identified. SCDFS documented during a supervisory consultation that a neglect petition would be filed; however, the record did not reflect this was completed. SCDFS reported they consulted with their legal department on 1/23/23, 2/6/23 and 2/24/23 regarding a removal of the children and their efforts to do so were denied. SCDFS made a phone call to the parents' substance abuse treatment provider; however, documented that the treatment provider refused to provide SCDFS with information. The safety assessments did not accurately reflect case circumstances.

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

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The 7-day and investigation determination safety assessment tools did not accurately reflect the concerns for the parents' substance abuse or the safety plan the parents signed on 2/6/23.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Issue:

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

Summary:

The record did not reflect attempts to locate and interview the two unrelated home members identified as subjects in the 2/5/23 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.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The SM tested positive for cocaine, morphine, methadone, and THC, resulting in a positive toxicology for the SS and withdrawal symptoms. The SM admitted to using heroin. The SF did not see the mother's relapse as a concern and appeared sluggish during a home visit. The SC was in the parents' care, and there were no interventions put in place to ensure the safety of the SC until 2/6/23.

Legal Reference:

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

Action:

SCDFS will document all applicable actions and considerations with respect to safety planning, including but not limited to: including all family members when devising the plan; adequately monitoring the plan; and, consulting the legal department if there is reason to believe the safety plan may not be sufficient to protect the child(ren).

Issue:

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

Summary:

The record did not reflect a Plan of Safe Care (POSC) was completed with the mother.

Legal Reference:

17-OCFS-LCM-03 & 18-OCFS-LCM-06

Action:

SCDFS will complete, document & monitor a Plan of Safe Care that specifically addresses the child(ren) affected by substance misuse and the affected caregiver. SCDFS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

The record did not reflect that SCDFS attempted to contact the source of the 1/31/23 SCR report.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

SCDFS 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/02/2022	Deceased Child, Female, 4 Months	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 4 Months	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 4 Months	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 4 Months	Father, Male, 40 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged that the mother and father were using heroin while caring for the subject child. On 5/2/22, the parents were extremely impaired. The mother was passed out and non-responsive and the father was nodding off. The child was not injured.

Report Determination: Unfounded | **Date of Determination:** 07/18/2022

Basis for Determination:
SCDFS unsubstantiated the allegations against the parents. SCDFS reflected in their investigation conclusion narrative that the SF was observed to be impaired by SCDFS staff. The SC was with the SF and a family friend. A plan was made for the SC to go to her MGM's home. The SF admitted to using heroin but reported it was a "hiccup" and he had not used it since. The SM had no positive toxicology screens. The parents were not observed to be under the influence during the CPS investigation and they were still engaged in treatment. Even though the SF had been using drugs at the time the SCR report was made, there was no impact on the SC, as she had stayed with her MGM.

OCFS Review Results:
On 5/4/22, SCDFS implemented a safety plan due to drug use by the parents, their homelessness, and the SM's incarceration. On 6/9/22, the parents did not follow the safety plan and took the SC from the MGM's care. SCDFS altered the safety plan to allow the SC to remain with the parents as long as they were compliant with substance abuse treatment, housing services, and mental health treatment. On 6/28/22, the parents' substance abuse counselors reported no concerns for them; however, the case was closed on 7/18/22 and there was no updated information regarding the requirements of the safety plan at that time. The record did not reflect safe sleep guidance was provided.

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

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The safety assessment at the time of case closure did not reflect the concerns about the parents' drug use and the SF's mental health. In addition, it did not reflect that SCDFS requested that the SF submit to a mental health evaluation and that the parents continued their engagement in their substance abuse treatment program. The parents signed a written safety plan on 6/9/22.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

The safety plan made was not accurately reflected in the Safety Assessments, nor was it adequately addressed with the parents. Despite documentation in the notes that a safety plan was devised with the family, the assessment documented no safety factors and no safety plan.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

SCDFS implemented a safety plan on 6/9/22. On 6/28/22, SCDFS contacted the parents' substance abuse counselors, which revealed no concerns; however, the case was not closed until 7/18/22, and there was no updated information regarding the parents' treatment or the father's recommendation to attend a mental health evaluation.

Legal Reference:

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

Action:

Prior to making a determination, SCDFS 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.

Issue:

Failure to provide safe sleep education/information

Summary:

While the SC was in the care of the MGM as part of SCDFS' safety plan, a Pack 'N Play was observed with a broken railing and the record did not reflect a new one was offered or that safe sleep guidance was provided. Though a Pack 'N Play was observed when visits were completed with the parents, the record did not reflect safe sleep guidance was provided to them.

Legal Reference:

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

Action:

13-OCFS-ADM-02 notes a review and assessment of a child's sleeping environment must be documented, and immediately addressed if assessed to be unsafe. In all CPS investigations with an infant in the home, caregivers must be provided with safe sleep information.

Issue:

Assessment as to need for Family Court Action

Summary:

There was a meeting with legal on 5/17/22. As a result, a safety plan was put in place for the SC to stay with the MGM. When the parents took the SC from the MGM on 6/9/22, the record did not reflect the safety concerns had been addressed eliminating the need for the plan and that SCDFS' legal department was consulted regarding the parents' unwillingness to follow the plan.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:

SCDFS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/26/2021	Deceased Child, Female, 20 Days	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 20 Days	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Deceased Child, Female, 20 Days	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 20 Days	Father, Male, 40 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged that at the time of the subject child's birth, the mother tested positive for cocaine and methadone. The mother had a prescription for methadone. The mother and father were impaired at the time of arrival to the hospital. The mother only had one prenatal visit and the child was born at 37 weeks gestation. The child was jittery from withdrawal. There was no plan of safe care in place.

Report Determination: Unfounded | **Date of Determination:** 02/17/2022

Basis for Determination:
SCDFS unfounded the investigation and determined there was a lack of evidence and no lasting impact on the child. SCDFS supported their determination by stating that during the investigation, the mother admitted that she relapsed and did cocaine on Christmas. SCDFS wrote that the child did not suffer withdrawal symptoms which were severe enough to transfer her to a different facility and she was released to the parents. Legal consults and family review board meetings were held and there was no evidence to substantiate against the parents. The family was actively working with preventive services and public nursing.

OCFS Review Results:
SCDFS completed casework and collateral contacts and reviewed safe sleep guidance. SCDFS had a safety plan in which the SF was to be the supervising caregiver and was visibly impaired during a home visit. The SM tested positive for drugs between September 2021 and December 2021. The SF refused to sign a release for his substance abuse Tx provider. On 12/27/21, SCDFS informed their legal department of the SCR report. SCDFS consulted with their legal department on 1/4/22 and were informed they could not access family court based on the information they provided. SCDFS did not consult their legal department after 1/4/22, at which time there was new information that impacted the SC's safety.

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

Issue:
Appropriateness of allegation determination

Summary:
The allegations were incorrectly determined. The SC tested positive for cocaine and experienced withdrawal symptoms including tremors and impacted sleep. The SF was visibly impaired during an unannounced home visit, while under a safety plan, which required him to supervise the SM's contact with the SC.

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

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

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

Summary:
Though SCDFS documented that they completed a plan of safe care, the details of the plan were not documented, nor were the ongoing concerns for substance abuse adequately monitored.

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

Action:

SCDFS will complete, document & monitor a Plan of Safe Care that specifically addresses the child(ren) affected by substance misuse and the affected caregiver. SCDFS will complete the required form (OCFS-2196 Plan of Safe Care) when developing and documenting the Plan of Safe Care with the family.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The SM was testing positive for drugs leading up to the birth of the SC. Following the SC's birth, the SM provided cold urine and refused drug screens. The SF appeared to be impaired during a visit and refused to sign a release for his substance abuse treatment. It was not documented that these concerns were addressed with the parents or that the safety plan's appropriateness was reassessed.

Legal Reference:

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

Action:

SCDFS will document all applicable actions and considerations with respect to safety planning, including but not limited to: including all family members when devising the plan; adequately monitoring the plan; and, consulting the legal department if there is reason to believe the safety plan may not be sufficient to protect the child(ren).

Issue:

Assessment as to need for Family Court Action

Summary:

SCDFS consulted their legal department on 1/4/22 and were informed they could not access family court with the information provided. Following the consult, SCDFS had additional information and the record did not reflect that this information was discussed with their legal department to determine if family court action could be sought with the additional information gathered.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:

SCDFS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The investigation determination safety assessment tool did not accurately reflect the safety concerns and the safety plan in place at the time of case closure.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

Prior to making a determination, SCDFS will complete an assessment of the current safety and the risk of future abuse and maltreatment to the children in the home and document such assessment in the form and manner provided by OCFS.

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

The Administration for Children's Services (ACS) had a CPS investigation regarding the mother in 2018. The mother was indicated for Parent's Drug/Alcohol Misuse and Inadequate Guardianship regarding a half-sibling. The mother admitted to snorting heroin and abusing drugs and was placed in a shelter where she continued to test positive for opiates. ACS intervened and removed that sibling from the care and custody of the mother.

Known CPS History Outside of NYS

The father reported he had a child who died that resided in Connecticut. The father reported that while he believed the mother of that child was responsible for the death, the coroner ruled the death to be the result of SIDS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 02/08/2023

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 02/08/2023

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☐	☒	☐	☐
Did all service providers comply with mandated reporter requirements?	☐	☐	☒	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☐	☒	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine

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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The FASP was due on 3/10/23. It was submitted timely on 2/27/23 and approved late on 3/13/23.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☐	☒	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: SCDFS contracted with a community-services agency to provide services to the family.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Failure to provide safe sleep education/information
Summary:	Although safe sleeping recommendations were provided in the CPS investigation that began on 3/21/23, the record did not reflect safe sleeping education was provided during the services case.
Legal Reference:	13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-

Action:	SCDFS must assess whether children in the home have a safe place to sleep, provide the parent or caregiver with information on the subject of safe sleep, and document when it was provided. SCDFS is required to share this ADM and attachment with each preventive services agency with which they have a contract and to monitor that the agency is complying with the requirements of the ADM.

Issue:	Failure to Monitor
Summary:	The preventive services case had a CPS program choice; however, did not have a CPS worker/monitor assigned until 5/5/23, nor did the record reflect the case was being monitored by CPS otherwise.
Legal Reference:	18 NYCRR 432.2(b)(5)
Action:	CPS is responsible for monitoring the provision of services, including foster care services, to children named in open indicated abuse and maltreatment reports and their families, when the CPS worker is not the primary service provider for the case.

Issue:	Adequacy of Child Protective Services casework contacts (open services)
Summary:	Between 2/14/23 and 5/2/23, there were nine face-to-face contacts with the family; however, only two of those contacts included an assessment of the condition of the children and the home.
Legal Reference:	18 NYCRR 432.2(b)(4)(vi)
Action:	When CPS is the primary service provider to children named in indicated CPS case and their families, the CPS worker must make casework contacts which, at a minimum, consist of at least two separate face-to-face contacts per month with the subject(s) and other persons named in the report, at least one of which must take place in the home.

Issue:	Coordination of Services
Summary:	The record did not reflect the goals related to substance abuse treatment were discussed with the parents or monitored via collateral contacts.
Legal Reference:	18 NYCRR 432.2(b)(4)(i) and 432.2 (b)(4)(viii)
Action:	When CPS is the primary service provider to families named in IND CPS cases, CPS is responsible for providing or coordinating services to reduce the risk to the CHN in the IND case. The CPS worker must ensure that the roles, responsibilities and tasks and activities of all service providers are clearly defined and that the established plan of service is being implemented.

Preventive Services History

On 1/28/22, SCDFS opened a preventive services case for the family after the mother tested positive for cocaine and methadone at the time of the subject child's birth. A safety plan was made that the mother would not be unsupervised with the child and the father was to provide supervised contact. The parents were requested to maintain a safe home and engage in their treatment program. On 1/28/22, it was documented in a progress note that "without the constant support of CPS, Public Health Nursing, and Preventive caseworkers, the infant is at imminent risk of placement." Despite this, the services case was closed at the parents' request on 2/28/22 with no apparent change in case circumstances.

On 2/8/23, a preventive services case was opened for the family to address concerns regarding the parents' substance

abuse, assist in obtaining housing and supplies for the sibling and providing parenting classes. The record indicated that without preventive services, the children were at risk of placement in foster care. Referrals were made to healthy families, a public health nurse and supports for housing. The parents were minimally cooperative with service providers. The record did not reflect the concern regarding the parents' substance abuse was monitored. Following the death of the child the case remained open and the sibling was placed in foster care.

Foster Care Placement History

Between January 2018 and February 2021, the mother had an open foster care services case in New York City regarding a half-sibling. The mother tested positive for opiates on 1/5/18. A neglect petition was filed on 1/12/18 and the sibling was remanded to kinship foster care with her maternal aunt. The sibling was discharged from foster care to her father on 5/2/19. The mother did not complete court orders and had limited/sporadic contact with the sibling as of the final FASP and closing of the case on 2/3/21.

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