Child Fatality Report

Report Identification Number: AL-24-024

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

Issue Date: Feb 26, 2025

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
Age: 24 day(s)
Jurisdiction: Clinton
Gender: Female
Date of Death: 09/11/2024
Initial Date OCFS Notified: 09/12/2024

Presenting Information

An SCR report alleged on 09/09/24, at about 10:00 PM, the parents placed the child in an unsafe sleeping environment. The child was placed in a bassinet with blankets and a pillow. On 09/10/24, at about 6:00 AM, the father found the child unresponsive and bleeding from the nose. The mother performed CPR and called 911. EMS arrived and took over lifesaving measures while transporting the child to the hospital where she was pronounced deceased. On 08/18/24, when the child was born, the mother was impaired by marijuana and the father was impaired by an unknown substance. The parents were anxious and nodded off. Due to their impairment, the parents failed to appropriately feed the child and did not follow safe sleeping recommendations by putting blankets in the child's bassinet.

Executive Summary

This report concerns the death of the 24-day-old child that occurred on 09/11/24. A report was made to the SCR on 09/12/24. The SCR report alleged that the parents placed the child in an unsafe sleeping environment and later found the child unresponsive and bleeding from the nose. The child was later pronounced deceased. There were concerns the parents were impaired by an unknown substance while caring for the child. The SCR report was subsequent to an investigation that began on 08/18/24 with concerns the mother gave birth to the child and previously had children removed from her care. At the time of the child's death, she resided with her parents. There were 3 siblings, children of the mother, who resided with their relatives. Neither the mother nor father had caretaking roles for the siblings. They were assessed to be safe with their relatives.

Clinton County Department of Social Services (CCDSS) coordinated investigative efforts with law enforcement. An autopsy was performed; however, was not yet available at the time of this writing. The record reflected the preliminary autopsy report noted the child's body was unremarkable and was without marks. The criminal investigation remained open, pending the autopsy report.

Inconsistent information was provided by the parents as to who found the child unresponsive, and they were inconsistent with what was in the bassinet with the child. The father called 911 and performed CPR until first responders arrived and took over resuscitation efforts to no avail.

CCDSS made collateral contacts with first responders, relatives, the father's parole officer and staff at the pediatrician's office. The relatives, including the siblings, did not have information regarding the death. Staff at the pediatrician's office reported safe sleeping recommendations were provided to the parents. There were no medical concerns for child.

CCDSS completed required reports timely and with accuracy. Home visits were made, and appropriate parties were interviewed. The record reflected gaps in casework activity. A supervisory review note dated 01/06/25 discussed the determination and it appeared the case was ready for closure; yet the investigation remained open until 01/24/25 for unknown reasons. Progress notes were entered untimely, and the investigation was closed untimely. Notice of Indication letters were not provided to the parents.

The allegation of IG was substantiated against the parents. DOA/Fatality and PD/AM were unsubstantiated. The Investigation Conclusion Narrative noted the father reported there were no blankets in the bassinet; however, the mother

told law enforcement that the child was placed in a Boppy pillow. The Investigation Conclusion Narrative was not consistent with information documented in the progress notes. The Conclusion reflected that the parents did not follow safe sleeping recommendations. DOA/Fatality was unsubstantiated as the investigation did not reveal "any acts of omission or commission regarding safe sleep being a cause of [the child's] death." PD/AM was unsubstantiated as there was no evidence that substance abuse was a factor in the child's death.

CCDSS offered the parents bereavement services and burial assistance. The parents accepted the burial assistance and declined counseling referrals.

PIP Requirement

CCDSS will submit a PIP to the Albany Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the CCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** 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:

Casework activity was not commensurate with case circumstances as the investigation remained open beyond 60 days. Notice of Indication was not provided to the parents. Progress notes were entered untimely.

Was the decision to close the case appropriate?	Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:

The fatality investigation was determined untimely on 01/24/25.

Required Actions Related to the Fatality

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

Issue:	Failure to Provide Notice of Indication
Summary:	Although Inadequate Guardianship was substantiated against the parents, the record did not reflect Notice of Indication was generated nor provided to the parents.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	Within 60 days, whether a report assigned to the investigative track is "indicated" or "unfounded", and if "indicated", CCDSS must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within 7 days of the determination, in such form as required by OCFS.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/11/2024 **Time of Death:** 06:50 AM

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

County where fatality incident occurred: Clinton
Was 911 or local emergency number called? Yes
Time of Call: 06:11 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	24 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)

LDSS Response

On 09/11/24, CCDSS learned of the death from an unknown party and began their investigation by contacting LE. Although CCDSS had not yet received an SCR report regarding the fatality prior to beginning their investigation, CCDSS had a separate investigation open. On 09/12/24, CCDSS received the fatality report. CCDSS contacted the source of the report, notified the DA and coroner of the death, and completed a CPS history check. In 2023, the SM had a child die while in an unsafe sleeping environment. The SSs were assessed as safe with their respective relatives and were not in the care of the SM.

The record reflected a collateral contact noted the SF seemed “anxious and jittery” while at the hospital.

On 09/11/24, CCDSS gathered information from the SM and grandmother. The SM reported waking up and the SC did not look normal and was pale. She reported the SF called 911 and performed CPR. The maternal great grandmother said she saw the SC the day prior to her death, and she appeared fine. The parents declined further communication with CCDSS at that time, noting they had previously provided their recollections of the death to LE.

CCDSS gathered information from LE. LE noted the SM said the parents were on the bed and the SC was in a bassinet prior to the parents finding her unresponsive. There was a u-shaped pillow in the bassinet, along with a blanket. The LE officer did not observe injuries on the SC.

CCDSS obtained further information from the investigation conducted by LE. The SM was interviewed and reported that there was nothing out of the ordinary prior to the death. Around 12:00 AM on 09/11/24, she changed the SC’s diaper and fed her before going back to sleep. The SF was awake with the SC around 2:00 AM. When the SM woke up, the SC was grey and had dried blood in her nose and she began yelling. She reported the SC was not ill prior to the death.

The SF reported to LE that on 09/11/24, between 2:00-3:00 AM, he fed and burped the SC before placing her on her back in the bassinet with a pacifier. The SF reported the SC was swaddled. The SF reported nothing was in the bassinet yet said there was a receiving blanket they wrapped the SC in along with a bed that went inside of the bassinet. At about 5:45 AM, he woke up and checked on the SC who was not responding. The SF recalled the SC had her arms by her chest and that she was warm and limp. He kicked the SM to wake her. He lightly shook the bassinet and called 911. During this interview, a LE officer stated the SM reported placing the SC on a “donut” pillow with her head on the pillow. Further information was not documented to have been explored.

CCDSS gathered information from emergency medical technicians (EMT). An EMT reported the SM said she woke and found the SC unresponsive and was laying “in a donut” inside of her bassinet. Another EMT reported arriving at the home and a firefighter was performing CPR. The EMTs attached an automated external defibrillator to the SC, and no shock was advised. The record reflected medical direction was obtained from a doctor who determined lifesaving measures would be discontinued.

A relative was contacted. She reported that the parents were great. She said the parents placed the SC to sleep on a Boppy pillow with a blanket over it, and would cover the SC with a blanket, with her arms over the blanket so it would not go over her face.

The record did not reflect casework activity took place from 09/18/24 to 10/18/24. There was no documented casework activity between 11/21/24 to 01/06/25. The last documented attempt to contact the parents was on 01/08/25. The case was closed untimely on 01/24/25.

Official Manner and Cause of Death

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

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: The death was referred to an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069807 - Deceased Child, Female, 24 Day(s)	069808 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated
069807 - Deceased Child, Female, 24 Day(s)	069808 - Father, Male, 23 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
069807 - Deceased Child, Female, 24 Day(s)	069809 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
069807 - Deceased Child, Female, 24 Day(s)	069809 - Mother, Female, 27 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
069807 - Deceased Child, Female, 24 Day(s)	069808 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated
069807 - Deceased Child, Female, 24 Day(s)	069809 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐

Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

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:
A risk assessment was not necessary as the siblings were not listed on the report, nor were they in the RAP family unit. Appropriate services were offered to the parents in response to the death. However, the record did not reflect the mother was provided with family planning information.

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?	☐	☒	☐	☐

Explain as necessary:
The siblings resided with relatives and did not need to be removed.

Legal Activity Related to the Fatality

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

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The mother noted she had 7 pregnancies by the time she was 27 years old; however, the record did not reflect family planning assistance was offered to her.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The parents were offered bereavement services; however, declined them. The family utilized burial assistance.

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

Infants Under One Year Old

Infant was born:

☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ With none of the issues listed noted in case record

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)
08/18/2024	Deceased Child, Female, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 1 Years	Father, Male, 23 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report alleged on 08/18/24, the mother gave birth to the child. Prior to the birth, the mother had 4 children removed from her care due to maltreatment/abuse. Further information regarding the previous concerns were unknown.

Report Determination: Indicated	**Date of Determination:** 01/24/2025

Basis for Determination:
The Investigation Conclusion Narrative stated the SM had a prior indication for not following safe sleeping recommendations. While hospitalized, the SC was in an unsafe sleeping environment on several occasions. Hospital staff observed a blanket over the SC's face and observed a blanket around and under the SC. CCDSS provided "casework counseling regarding safe sleep practices;" yet the parents did not practice safe sleeping recommendations.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. IG was added against the SF. Safe sleeping recommendations were provided to the parents by the hospital, pediatrician and by CCDSS. Preventive services were offered and declined. The child died during the investigation. There was not documented casework activity between 09/16/24-11/12/24 or from 11/23/24-01/08/25. On 11/12/24, a supervisory note documented the decision to substantiate Inadequate Guardianship, yet the case remained open until 01/24/25. The last documented attempt to contact the family was on 01/08/25. There were progress notes that were entered untimely. Notice of Indication was not provided.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day Safety Assessment was completed 9 days late on 09/03/24.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
CCDSS will document and approve all Safety Assessments within the required timeframes.

Issue:
Timeliness of Determination
Summary:
The investigation was not completed timely. The investigation should have been closed within 60 days of the receipt of the SCR report; however, the investigation was closed on 01/24/25. The investigation was closed 99 days late.
Legal Reference:
SSL 424(7);18 NYCRR 432.2(b)(3)(iv)
Action:
CCDSS will make a determination of either “indicated” or “unfounded” within 60 days after receiving the report.

Issue:
Failure to Provide Notice of Indication
Summary:
Although Inadequate Guardianship was substantiated against the parents, the record did not reflect Notice of Indication letters were provided to them.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:

Within 60 days, whether a report assigned to the investigative track is "indicated" or "unfounded", and if "indicated", CCDSS must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within 7 days of the determination, in such form as required by OCFS.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/15/2023	Sibling, Male, 1 Months	Other Adult - Father of Deceased Sibling, Male, 26 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 1 Months	Mother, Female, 26 Years	DOA / Fatality	Unsubstantiated	
	Sibling, Male, 1 Months	Other Adult - Father of Deceased Sibling, Male, 26 Years	DOA / Fatality	Unsubstantiated	
	Sibling, Male, 1 Months	Other Adult - Unrelated Adult, Female, 65 Years	DOA / Fatality	Unsubstantiated	
	Sibling, Male, 1 Months	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Months	Other Adult - Unrelated Adult, Female, 65 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged that on 02/15/23, the mother and now deceased sibling's father found the sibling unresponsive in his crib at 9:52 AM. First responders arrived at the home, began CPR, and transported the sibling to the hospital where he was pronounced deceased. The report noted the mother, sibling's father, and an unrelated adult were responsible for the death as the sibling was otherwise healthy, had no preexisting medical conditions, and the caretakers provided no explanation for the death.

Report Determination: Indicated | **Date of Determination:** 06/28/2023

Basis for Determination:
The unrelated adult was unsubstantiated for IG. The sibling's parents were substantiated for IG and were unsubstantiated for DOA/Fatality. The Investigation Conclusion Narrative noted the sibling's parents placed the sibling in an unsafe sleeping environment. DOA/Fatality was unsubstantiated as a fair preponderance of evidence was not revealed.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A home visit was made, and the family was interviewed. Collaterals were interviewed. Required reports and Safety Assessments were completed timely and accurately. The open Services case was closed on 02/17/23 as the sibling died and there were no other children in the care of the adults.

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)
01/13/2023	Sibling, Male, 1 Years	Other Adult - Father of Deceased Sibling, Male, 26 Years	Inadequate Guardianship	Substantiated	Yes

Sibling, Male, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 1 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged the mother gave birth to the now deceased sibling. The sibling had a positive toxicology for cocaine at the time of delivery and showed signs of withdrawal. The mother tested positive for marijuana and cocaine.

Report Determination: Indicated

Date of Determination: 03/18/2023

Basis for Determination:
The Investigation Conclusion Narrative noted there were ongoing concerns for the mother and the sibling's father's parenting abilities. The parents were educated multiple times regarding safe sleeping practices by medical staff and by CCDSS caseworkers; however, the parents continued to place the sibling in unsafe sleeping environments. Inadequate Guardianship was substantiated against both parents. The Investigation Conclusion Narrative noted the sibling was placed at significant risk of harm by his parents' actions. Parent Drug/Alcohol Use was unsubstantiated as the medical staff denied the sibling showed symptoms of withdrawal.

OCFS Review Results:
The 7-day Safety Assessment was completed timely but was inaccurate. CCDSS did not adequately document a Plan of Safe Care, despite the sibling's positive toxicology for cocaine at birth. A check of the family's CPS history was not documented timely. The mother reported she had multiple children in the care of other people with whom she had visitation; however, those siblings and their respective fathers were not added to the case composition.

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day Safety Assessment was inaccurate and did not reflect the ongoing substance misuse concerns for the mother nor did it reflect concerns from hospital staff that the mother regularly failed to follow safe sleeping guidelines with the now deceased sibling.

Legal Reference:

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

Action:

CCDSS will document and approve all assessments and accurately reflect the safety factors that are present.

PIP Requirement:

Due to a prior review of this case, a new PIP will not be required.

Issue:

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

Summary:

The record reflected CCDSS developed a Plan of Safe Care; however, the plan was not documented or monitored as required.

Legal Reference:

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

Action:

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

PIP Requirement:

Due to a prior review of this case, a new PIP will not be required.

Issue:

Review of CPS History

Summary:

The record reflected a review of CPS history was not completed until day 4 of the investigation.

Legal Reference:

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

Action:

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

PIP Requirement:

Due to a prior review of this case, a new PIP will not be required.

Issue:

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

Summary:

The mother had 3 children who were not in her care, but reported there was no custody established. The record reflected the mother had visitation and contact with 2 of the children; however, the children and their respective fathers were not added to the case composition and face-to-face contact was not attempted.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

CCDSS 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.

PIP Requirement:

Due to a prior review of this case, a new PIP will not be required.

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

The mother was the subject of 9 reports more than 3 years prior to the fatality regarding the now 8-year-old sibling. Of those reports, 6 were unfounded. The indicated investigations are detailed below.

In 2016, the mother and the father of the 8-year-old sibling were listed as indicated subjects for the substantiated allegation of Inadequate Guardianship after allowing the now 8-year-old sibling to be unsupervised with a sex offender.

In 2017, the mother and the father of the 8-year-old sibling were listed as indicated subjects for the substantiated allegations of Inadequate Guardianship and Lack of Supervision after leaving the sibling alone and unsupervised in a hotel room while they left to smoke cigarettes.

In 2018, the mother and father of the 8-year-old sibling were listed as indicated subjects for the substantiated allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter after the home was found to be unfit with human feces, garbage, and drug paraphernalia in reach of the sibling. The parents physically fought in the presence of the sibling.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Preventive Services History

On 01/23/23, a Preventive Services Case was opened listing the mother and now deceased sibling as service recipients. The mother used crack cocaine throughout her pregnancy and the sibling was born with a positive toxicology for cocaine. The mother accepted Services and engaged with substance abuse treatment. CCDSS coordinated with the family and service providers and assisted with transportation to medical and substance abuse treatment appointments. The mother and sibling initially resided with the maternal grandmother and the then 11-year-old sibling; however, left that home after the father of the now deceased sibling was released from jail. The mother, father of the sibling, and now deceased sibling stayed in emergency public housing at a motel. The then 11-year-old sibling began residing with a relative. CCDSS made frequent casework contacts with the family and made appropriate referrals as needs arose.

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