Child Fatality Report

Report Identification Number: BU-19-036

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

Issue Date: Mar 12, 2020

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Allegany
Gender: Male
Date of Death: 10/01/2019
Initial Date OCFS Notified: 10/01/2019

Presenting Information

An SCR report alleged on 10/1/19, while the parents were home, a home member placed the 2-month-old male subject child in his crib at 12:30 PM. At around 2:40 PM, the home member found the child unresponsive, not breathing and wrapped in a heavy blanket. The crib contained heavy blankets and a lighter. The room temperature was approximately 82 degrees. The home member took the child out of the crib and to a neighbor's home, where CPR was attempted. EMS was contacted and when they arrived, they transported the child to the hospital where the child was pronounced deceased. Prior to his death, he was an otherwise healthy child and the adults did not provide an explanation for his death. The child often shared a crib with his twin, but the twin was not in the crib at the time the child was found unresponsive. The home was cluttered and there were dirty clothes on the floor, dirty dishes and drugs accessible to other children in the home, who were 2 years old.

Executive Summary

This fatality report concerns the death of the 2-month-old male subject child who died on 10/1/19, an SCR report was received on the same day and a subsequent report regarding the death was received on 12/17/19. There were three other children in the home at the time of the fatal incident; a twin sibling and a 2-year-old sibling who resided there, and a 2-year-old unrelated child who was staying there temporarily. Their safety was assessed throughout the investigation. Additionally, another adult resided in the home, along with the mother of the unrelated child. Prior to case closure, the unrelated child and his mother moved out of the home.

Allegany County Department of Social Services (ACDSS) coordinated investigative efforts with law enforcement upon the initial report. At the time this report was written, the parents were arrested for Felony Criminally Negligent Homicide and Endangering the Welfare of a Child.

ACDSS gathered information regarding the death from the parents and home members, law enforcement and other first responders, family friends, the pediatrician and the medical examiner. An autopsy was completed, and the medical examiner declared the cause of death as positional asphyxia, with a contributing factor of hyperthermia. The manner of death was accidental.

ACDSS and law enforcement gathered information the parents swaddled the child and placed him in a playpen with the twin sibling on 9/30/19 between 10:30-11:00 PM. Interviews with the parents clarified no one adequately checked on the child until approximately 12 hours later when a household member (OA) found the child face-down, stiff and purple in the playpen. CPR was performed and 911 was contacted.

EMS arrived at the case address and took over resuscitation efforts; however, requested a field termination as it was apparent the child was deceased. The field termination was denied, and the child was transported to the hospital via ambulance where he was pronounced deceased.

Due to concerns for the surviving children, ACDSS made immediate and appropriate safety plans for the 2-year-old other child to stay with his grandparents, and the siblings were temporarily placed with a family friend. On 10/3/19, ACDSS conducted an emergency removal of the siblings and they were placed in Foster Care. An Abuse Petition was filed against the parents regarding the child and his siblings. A Family Services Stage was opened on 10/4/19 to provide services to the family and work toward reunification. ACDSS offered appropriate services in response to the fatality, including

bereavement service referrals.

ACDSS documented a CPS history check within New York State as well as South Carolina, where family members had resided. Although documented, the CPS history check was not completed timely. ACDSS completed Safety Assessments and the Risk Assessment Profile accurately; however, the record did not reflect a 30-day Safety Assessment was completed. The record did not reflect the parents of the children listed on the report were provided with written notice of the SCR report or letters of indication. Additionally, although identified, the record does not reflect attempts to contact the father of the other child.

ACDSS substantiated the allegation of DOA/Fatality regarding the child against the parents as they did not follow safe sleep recommendations and knowingly placed their infant children in unsafe sleep environments, which resulted in the child's death. The allegation of Inadequate Guardianship was substantiated against the household member regarding her child as she left drug paraphernalia accessible to the children. The investigation conclusion narrative documented ACDSS did not establish the home member was a person legally responsible for the child and his siblings; however, substantiated the home member regarding the Inadequate Guardianship of the child.

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
The investigation was closed after a through investigation was completed.

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 case remained open at the time of this writing as the siblings remained in Foster Care and ACDSS was working with the family through a Family Service Stage in attempt for reunification.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect attempts were made to locate or interview the father of the OC.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACDSS will contact or make diligent efforts to contact collateral sources who may have information relevant to the investigation, including absent parents.
Issue:	Failure to provide notice of report
Summary:	The record did not reflect written notice was provided to the unrelated home member who was listed on the report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.
Issue:	Failure to Provide Notice of Indication
Summary:	Although the parents were provided with written notice regarding the indicated finding of the report, the record did not reflect all adults were provided with written notice regarding the indication.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	Written notice of an indicated investigation will be provided to the adults on the report as well as the parents of children listed on the report upon case closure.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The record does not reflect a 30-day Safety Assessment was completed.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACDSS will complete all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.
Issue:	Review of CPS History
Summary:	Although a CPS history check was completed, and ACDSS contacted an agency outside of New York State, the history check was not documented timely. The CPS history check was completed on 10/7/19.
Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	Within 1 business day of a report, ACDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, ACDSS will review its own CPS

	record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/01/2019 **Time of Death:** Unknown

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

County where fatality incident occurred: Allegany
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

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Other Adult - Friend	No Role	Male	20 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Other Household 1	Other Adult - Family Friend	Alleged Perpetrator	Female	22 Year(s)
Other Household 1	Other Child - Family Friend's Child	Alleged Victim	Male	2 Year(s)

LDSS Response

ACDSS initiated their investigation immediately upon receipt of the initial SCR report by contacting LE, speaking to the source and made a home visit to the case address to interview the parents. The DA and ME's offices were made aware of the death.

On 10/1/19, the father was interviewed by ACDSS and LE. The father said on the night prior to the death, he swaddled the twins, and the mother put them into the playpen at 11:30 PM. The father said he did not wake up during the night to tend to the children. He woke at 8:00 AM and gave the twin a bottle and put the twin back in the playpen. Around that time, the father did not check on the child, but said he saw the child breathing by peeking at the child through the doorway. The child was in a playpen with a comforter and fans were running as the room was hot. The father left the home at 10:55 AM and went to work. At that time, the twin was downstairs with the mother and the sibling was at daycare. The other child was in a bedroom with the home member (OA).

The mother's recollection of the night prior to the death reflected the father's statement. Despite having safe sleep knowledge, the mother placed the child in his playpen face-down around 12:00 AM. On 10/1/19, the mother woke at 6:00 AM with the twin. She said the child did not wake during the night and she did not check on him, but saw him in the playpen and he was not moving. The mother was in and out of the house between 8:10 AM-11:30 AM running errands and left the sibling with OA. When she came home, she changed the twin's diaper with the OA and believed the subject child was fine. The mother said the child normally sleeps through the night and into the middle of the afternoon, but usually woke up for a feeding around 8:30 AM. Later in the morning, the mother asked the OA to check on the child stating, "he should be getting up by now."

The OA went to the bedroom and found the child face-down in the playpen. She said the child did not look right and was stiff and purple. The OA ran downstairs with the child, and the mother brought the child to a neighbor who performed CPR while 911 was called. The neighbor described the child to be lifeless, cold and blue. She stated the mother had previously asked her to take one of the twins on multiple occasions because he cried constantly.

EMS responded to the scene and took over resuscitation efforts. The child had no heartbeat and had lividity in his arms, legs, face and chest. EMS requested a field-termination; however, termination was denied, and the child was transported to the hospital.

Due to the unexplained death, on 10/1/19, ACDSS appropriately created a safety plan for the surviving siblings with the parents and a friend of the family. The safety plan included supervised visits with the parents, and the other child was to be supervised by his maternal grandparents until the OA was enrolled in substance abuse treatment and obtained independent housing. The friend of the family's home was assessed to be safe for the siblings, and she was interviewed. The friend said on 9/19/19, she was at the case address and heard the child screaming. She said she looked in the playpen and saw many blankets inside. She picked up the child and saw movement under the blanket. The twin sibling was in the playpen, face-down, under three blankets.

The other home member was contacted and had no additional information regarding the death.

On 10/3/19, LE arrested the parents for Criminally Negligent Homicide and Endangering the Welfare of a Child. The outcome of the criminal investigation was pending at the time this report was written. In response to the death and the criminal arrest, ACDSS removed the siblings from their parents on 10/3/19, with the parents' consent. An abuse petition was filed in Family Court regarding the child and his siblings. The children remained in Foster Care at the time this report was written and ACDSS was providing services in attempt to reunite the family.

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 reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053134 - Deceased Child, Male, 2 Mons	053140 - Other Adult - Family Friend, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
053134 - Deceased Child, Male, 2 Mons	053138 - Father, Male, 21 Year(s)	DOA / Fatality	Substantiated
053134 - Deceased Child, Male, 2 Mons	053139 - Mother, Female, 21 Year(s)	DOA / Fatality	Substantiated
053134 - Deceased Child, Male, 2 Mons	053140 - Other Adult - Family Friend, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
053134 - Deceased Child, Male, 2 Mons	053138 - Father, Male, 21 Year(s)	Lack of Supervision	Substantiated
053134 - Deceased Child, Male, 2 Mons	053139 - Mother, Female, 21 Year(s)	Lack of Supervision	Substantiated
053134 - Deceased Child, Male, 2 Mons	053138 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
053134 - Deceased Child, Male, 2 Mons	053139 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
053135 - Sibling, Male, 2 Month(s)	053140 - Other Adult - Family Friend, Female, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
053135 - Sibling, Male, 2 Month(s)	053138 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
053135 - Sibling, Male, 2 Month(s)	053139 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
053136 - Sibling, Male, 2 Year(s)	053139 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
053136 - Sibling, Male, 2 Year(s)	053138 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
053136 - Sibling, Male, 2 Year(s)	053140 - Other Adult - Family Friend, Female, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
053141 - Other Child - Family Friend's Child, Male, 2 Year(s)	053140 - Other Adult - Family Friend, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
053141 - Other Child - Family Friend's Child, Male, 2 Year(s)	053139 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
053141 - Other Child - Family Friend's Child, Male, 2 Year(s)	053138 - Father, Male, 21 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

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

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 siblings were placed in Foster Care and ACDSS opened a Family Services Stage to monitor the family in an effort to reunite the family.

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?	☒	☐	☐	☐
If Yes, court ordered?	☐	☒	☐	☐

Explain as necessary:
The mother and father consented to the removal of the siblings on 10/3/19, prior to the initial court hearing.

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:**
10/07/2019	There was not a fact finding	There was not a disposition
Respondent:	053138 Father Male 21 Year(s)	
Comments:	The father consented to have the siblings placed in Foster Care. The father was awarded supervised visits with the siblings, and was ordered to complete psychological and drug abuse evaluations.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
10/07/2019	There was not a fact finding	There was not a disposition
Respondent:	053139 Mother Female 21 Year(s)	

Comments:	The mother consented to place the siblings in Foster Care and she appeared in court on 10/9/19 and was awarded supervised visits with the siblings. She was ordered to complete psychological and substance abuse evaluations.

Criminal Charge: Endangering the welfare of a child		**Degree:** NA	
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	The mother and the father	Pending	The disposition was pending at case closure.
Comments:	The parents were arrested for Endangering the Welfare of a Child and Criminally Negligent Homicide.		

Criminal Charge: Criminally negligent homicide		**Degree:** NA	
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	The mother and the father	Pending	Pending
Comments:	At the time this report was written, the criminal charges had not yet been determined.		

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:
ACDSS appropriately provided services to the family in response to the fatality.

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:
An Abuse Petition was filed in Allegany Family Court and a Family Services Stage was opened to provide ongoing services to the family. The siblings were placed in Foster Care as a result of the fatality investigation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was offered an abundance of services including bereavement services. The children were removed from the custody of their parents as a result of the fatality investigation.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

02/20/2019	Other Child - OC, Male, 1 Years	Other Adult - OA, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - OC, Male, 1 Years	Other Adult - OA's Partner, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - OC, Male, 1 Years	Other Adult - OA, Female, 21 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

Report Summary:
An SCR report alleged on 2/17/19, the OA's partner assaulted the OA in the presence of the OC. The OA's partner pushed her, spit in her face, made threats to harm her, blocked the exit and would not let her leave. The OC did not sustain injuries. A subsequent report was received on 3/10/19 alleging the OA did not keep the residence clean for the OC. There were dirty dishes, laundry and clutter inside the home. Due to the unsanitary condition, the apartment had a bad odor. The OC was dirty and unkempt. The OA never bathed the child and his ears were dirty and his nails were long. The OA did not tend to the OC's needs when he cried, instead she played on her cell phone.

Report Determination: Unfounded | **Date of Determination:** 03/11/2019

Basis for Determination:
ACDSS unsubstantiated the allegations against the OA and her partner. The investigation revealed the home and OC to be clean during home visits. During the investigation, the OA's partner moved out of the home and was arrested for Endangering the Welfare of a Child. ACDSS documented the OA's partner was no longer caring for the OC.

OCFS Review Results:
ACDSS contacted the source of the report and relevant collateral contacts. A CPS history check, and 7-day Safety Assessment were completed timely. The safety of the OC was assessed throughout the investigation and adequately documented. The record did not reflect attempts to contact the father of the OC or provide written notice of the report to the parents of the OC or the OA's partner.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
Although identified, the record does not reflect attempts to locate or interview the father of the OC.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACDSS will contact or make diligent efforts to contact collateral sources, including absent parents of children listed on an SCR report.

Issue:
Failure to provide notice of report
Summary:
The record does not reflect the adults listed on the report were provided with written notice of the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

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

There was no CPS history more than three years prior to the death.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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