# Child Fatality Report

## Report Identification Number: AL-18-006

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

## Issue Date: Dec 05, 2018

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 | | |

## Case Information

**Report Type:** Child Deceased
**Age:** 21 day(s)
**Jurisdiction:** Otsego
**Gender:** Female
**Date of Death:** 06/05/2018
**Initial Date OCFS Notified:** 06/05/2018

### Presenting Information

An SCR report received on 06/05/18 alleged that the SC, (Twin A) and Twin B were born prematurely on 05/15/18. The babies were in the hospital for approximately 3 weeks. The twins were discharged from the hospital on 06/04/18. The parents found Twin A unresponsive in her crib on 06/05/18 at about 6:30AM. The parents called EMS and EMS performed CPR for approximately a half hour before taking the baby to the hospital. EMS arrived at the hospital at 7:28AM and Twin A was in cardiac arrest. The hospital staff performed CPR for about a half hour before the baby died. The parents arrived at the hospital at approximately 8:15AM. Upon arrival, the parents were under the influence of drugs. It was unknown what type of drugs the parents had been using. Neither parent could open their eyes, were slurring their words and staggering. The SF went outside and when he returned to the ER, he passed out. The SF became a patient at the hospital and his urine toxicology came back positive for drugs.

### Executive Summary

This report concerns the death of the 21-day-old female child. The subject child (Twin A) was part of a multiple birth and was born approximately one month prematurely. Additionally, she was born with a positive toxicology for marijuana; however, she did not suffer any withdrawal symptoms. The death was reported to the SCR on 6/5/18 and assigned to Otsego County Department of Social Services (OCDSS) for investigation.

After her birth, the child remained in the hospital for nearly 3 weeks and was discharged on 6/4/18. The following day, around 6:30AM, the parents found the child unresponsive in a bassinet with her twin brother (Twin B) and called for EMS. When the parents arrived at the hospital, there were reported concerns of drug abuse as the parents appeared to be under the influence.

OCDSS obtained information from collateral contacts including medical professionals, EMS, the school of the 12yo SS, and the SS' mother. The mother of the 12yo SS had no concerns for the father's ability to care for the children. OCDSS interviewed the 12yo SS the following day, at her home, and there were no concerns noted for her safety. Twin B was assessed to be safe in the care of his grandparents and mother. OCDSS and the family made a safety plan for the father to not be the unsupervised around either SS while the investigation was underway, due to concerns of ongoing parental drug abuse and mental health concerns. All family members were made aware of this safety plan. Throughout the investigation, OCDSS made continuous casework contacts with the family.

On 6/16/18, a report was registered by the SCR regarding the death of Twin B. It alleged he was found dead in his bassinet by the parents around 4:15AM. CPS and LE continued their joint investigation into both deaths.

After thoroughly interviewing the family, it was learned both parents co-slept with the children since they were brought home from the hospital, despite having received education about safe sleep from the hospital and CPS both before and after the death of Twin A. During the investigation, the mother said she "may have suffocated" the children, while co-sleeping with them. Additional concerns were revealed by the father regarding the mother being under the influence of prescription drugs, not prescribed to her, at the times the children were found unresponsive. Investigation into the deaths of both twins was still underway at the time of this writing, with no arrests made.

An autopsy was performed, listing the cause and manner of death to be undetermined for both children. In addition to an autopsy, which found alcohol in Twin A's system, further testing was ordered, but was unsuccessful.

The family was offered burial assistance, economic support, mental health counseling and bereavement services. Additionally, OCDSS offered the family drug addiction counseling.

**PIP Requirement**
In response to the citations which resulted from this review, OCDSS will submit a Program Improvement Plan (PIP) to the Regional Office (RO) which will identify what actions have been taken, or will be taken, to address these concerns. If a PIP is currently in place, the plan will be reviewed and revised as needed.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

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

**Determination:**

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

**Explain:**
The CPS report had not yet been determined at the time this Fatality Report was written.

**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 record included documentation of supervisory consults and extensive casework contact during the investigation.

## Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment. |

| | |
|---|---|
| **Summary:** | Although a 24-hour Safety Assessment was completed timely, a 24-hour Fatality Report was not completed in Connections within 24 hours of receipt of the report. The 24-hour Fatality Report was approved 2 weeks after the due date. |
| **Legal Reference:** | CPS Program Manual, Chapter 6, K-1 |
| **Action:** | OCDSS must complete a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment. |
| | |
| **Issue:** | Timely/Adequate Case Recording/Progress Notes |
| **Summary:** | Some progress notes were not entered contemporaneously during the investigation, and were documented up to 3 months after the event date. |
| **Legal Reference:** | 18 NYCRR 428.5 |
| **Action:** | Progress notes must be entered as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded. |
| | |
| **Issue:** | Timely/Adequate 30-Day Safety Assessment |
| **Summary:** | The 30-day Safety Assessment was completed inaccurately. Although there was a safety plan in place that was referenced in the Safety Assessment, the appropriate safety decision was not selected. |
| **Legal Reference:** | CPS Program Manual, Chapter 6, K-2 |
| **Action:** | The results of each safety assessment must be accurately documented in the case record to reflect case circumstances with regard to safety. |
| | |
| **Issue:** | Adequacy of Documentation of Safety Assessments |
| **Summary:** | The 24-hour Safety Assessment was completed inaccurately. The safety decision did not include the safety plan or controlling interventions that were made with the family, which included not allowing the father to be unsupervised with the SS. |
| **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 with regard to safety. |
| | |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 06/05/2018 **Time of Death:** 08:04 AM

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

**County where fatality incident occurred:** Otsego
**Was 911 or local emergency number called?** Yes
**Time of Call:** 06:29 AM
**Did EMS respond to the scene?** Yes
**At time of incident leading to death, had child used alcohol or drugs?** Yes
**Child's activity at time of incident:**

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] Other

**Did child have supervision at time of incident leading to death?** Yes
**How long before incident was the child last seen by caretaker?** 2 Hours
**At time of incident supervisor was:** Unknown if they were 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 | Female | 21 Day(s) |
| Deceased Child's Household | Grandparent | No Role | Female | 56 Year(s) |
| Deceased Child's Household | Grandparent | No Role | Male | 56 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 27 Year(s) |
| Deceased Child's Household | Sibling | Alleged Victim | Male | 21 Day(s) |
| Other Household 1 | Other Adult - SS2's BM | No Role | Female | 45 Year(s) |
| Other Household 1 | Other Adult - SS2's MGM | No Role | Female | 64 Year(s) |
| Other Household 1 | Sibling | No Role | Female | 12 Year(s) |
| Other Household 2 | Father | Alleged Perpetrator | Male | 44 Year(s) |

**LDSS Response**

On 06/05/18, OCDSS received an SCR report regarding the death of the SC (Twin A), subsequent to an open investigation regarding the positive toxicology of the twins at birth. Upon receipt of the report, OCDSS immediately contacted law enforcement, notified the DA, completed a CPS record check, attempted to contact the source of the report, and assessed the safety of Twin B and the 12yo SS.

OCDSS conducted extensive casework contact interviews and completed a 24-hour Safety Assessment timely. OCDSS completed a 24-hour Fatality Report; however, the report was not approved in Connections until 15 days after the receipt of the report.

OCDSS and law enforcement completed a joint investigation regarding the death of Twin A. Initially, the family reported the twins were sleeping together in a bassinet, but were unable to touch one another. OCDSS observed the sleeping environment to meet safe sleep recommendations, which the parents had knowledge. The parents were provided safe sleep information both before and after the death of Twin A by OCDSS. Twin A was noted to be congested prior to her death, and was on special formula for acid reflux to prevent additional discomfort, approved by her Dr.

The family reported the mother found Twin A in the bassinet, face up, unresponsive and not breathing around 6:30AM. She alerted the father, who told the maternal grandmother. The maternal grandfather performed CPR while the mother called EMS, who arrived at the scene, took over resuscitation efforts and transported Twin A to the hospital. Twin A was in cardiac arrest upon hospital arrival and was pronounced dead at 08:04AM.

The maternal grandfather reported seeing blood on the child's neck, face and clothing while performing CPR and observed a fluid coming from her mouth.

Hospital staff reported the parents appeared to be under the influence of drugs when they arrived, after finding Twin A unresponsive. Furthermore, the father was seen going outside to his car and returned to the hospital where he made threats of self-harm, went unconscious, and was administered medication to reverse the overdose of opioids. As a result, the father was admitted to the hospital. He tested positive for illegal drugs and was admitted.

During the investigation of Twin A's death, OCDSS and law enforcement learned the Twin B was found unresponsive in his bassinet on 06/16/18. The Twin B was pronounced deceased the same day. The family said the events of discovering the Twin B and contacting EMS were identical to that of Twin A. The family did not report any new information regarding the deaths, at that time.

As the investigation continued, it was learned Twin A had alcohol in her system at the time of her death. The family was unable to provide an explanation for this, and the child's stomach contents were sent to a lab for further testing; however, there was not enough for testing to be completed. While the reason for the presence of alcohol remains unknown, it was not believed to have contributed to the death.

After the death of the Twin B, the family was questioned again regarding the incidents. The mother stated she may have suffocated the children while she was sleeping. The mother reported she was laying on her back and Twin A was between her legs when the child was found unresponsive. The father reported finding the mother seated in the bed, "slumped over" the child, chest to chest, "after passing out" from a drug she was not prescribed. The father said he pushed the mother off Twin A and found her unresponsive, limp and not breathing.

At the time this report was written, the investigations of both OCDSS and law enforcement remained open. A Family Court petition was under consideration, but had not been filed.

The Safety Assessments did not always accurately reflect the case record. The progress notes were not always entered contemporaneously to their event dates.

## Official Manner and Cause of Death

**Official Manner:** Undetermined
**Primary Cause of Death:** Undetermined if injury or medical cause
**Person Declaring Official Manner and Cause of Death:** Coroner

## Multidisciplinary Investigation/Review

**Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?** Yes
**Comments:** The fatality investigation was assigned to a Multi-Disciplinary Team.

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?** No
**Comments:** Otsego County Department of Social Services does not have an OCFS-approved Child Fatality Review Team at this time.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 046589 - Deceased Child, Female, 21 Days | 046590 - Mother, Female, 27 Year(s) | Parents Drug / Alcohol Misuse | Pending |
| 046589 - Deceased Child, Female, 21 Days | 046590 - Mother, Female, 27 Year(s) | Inadequate Guardianship | Pending |
| 046589 - Deceased Child, Female, 21 Days | 046590 - Mother, Female, 27 Year(s) | DOA / Fatality | Pending |
| 046593 - Sibling, Male, 21 Day(s) | 046590 - Mother, Female, 27 Year(s) | Parents Drug / Alcohol Misuse | Pending |
| 046593 - Sibling, Male, 21 Day(s) | 046590 - Mother, Female, 27 Year(s) | Inadequate Guardianship | Pending |

## CPS Fatality Casework/Investigative Activities

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

**Additional information:**

Some progress notes were not entered contemporaneously throughout the investigation. Some progress notes were entered approximately three months after the event date.

## 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:**
OCDSS appropriately offered a multitude of services to the family. The maternal grandparents refused services. The SF accepted mental health counseling, but would not provide details of his treatment. The family accepted and utilized funeral and burial services for Twin A.

**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?** | ☐ | ☒ | ☐ | ☐ |

**Explain as necessary:**
Twin B remained in the home for 10 days after the death of Twin A. After Twin A's death, Twin B was determined as safe with his parents and grandparents.

## Legal Activity Related to the Fatality

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

**Have any Orders of Protection been issued?** No

## 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 | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**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:**
No service needs were identified for the SS; however, OCDSS offered mental health counseling information to the SS' mother.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
OCDSS offered burial assistance, funeral assistance, trauma counseling, grief counseling, mental health counseling,

bereavement counseling and made drug treatment referrals for the family. Additionally, mental health counseling was offered to the SS and her mother.

## History Prior to the Fatality

### Child Information

| | |
|---|---|
| **Did the child have a history of alleged child abuse/maltreatment?** | Yes |
| **Was there an open CPS case with this child at the time of death?** | Yes |
| **Was the child ever placed outside of the home prior to the death?** | No |
| **Were there any siblings ever placed outside of the home prior to this child's death?** | No |
| **Was the child acutely ill during the two weeks before death?** | Yes |

### Infants Under One Year Old

**During pregnancy, mother:**

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

**Infant was born:**

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

## CPS - Investigative History Three Years Prior to the Fatality

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 05/21/2018 | Deceased Child, Female, 21 Days | Mother, Female, 27 Years | Parents Drug / Alcohol Misuse | Pending | Yes |
| | Sibling, Male, 21 Days | Mother, Female, 27 Years | Parents Drug / Alcohol Misuse | Pending | |

**Report Summary:**
An SCR report received on 5/21/18 alleged the mother gave birth to twins. The children's meconium tests came back positive for marijuana. The role of the father was unknown.

**Report Determination:** Undetermined

**OCFS Review Results:**
OCDSS made appropriate collateral contacts and made extensive casework contact. Although OCDSS later identified the error, the 7-day Safety Assessment was inaccurately completed. The record did not show OCDSS seeing or attempting to see Twin A. Twin B was not documented to have been seen by OCDSS until 17 days after the report was received, after being informed of Twin A's death.

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

**Issue:**

Review of CPS History

**Summary:**

OCDSS did not document reviewing any SCR or CPS history regarding the family until 3 days after the due date.

**Legal Reference:**

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

**Action:**

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

**Issue:**

Timely/Adequate Case Recording/Progress Notes

**Summary:**

Some progress notes were not entered contemporaneously during the investigation, and were documented up to 3 months after the event date.

**Legal Reference:**

18 NYCRR 428.5(a) and (c)

**Action:**

Progress notes must be entered as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

**Issue:**

Adequacy of Documentation of Safety Assessments

**Summary:**

The 7-day Safety Assessment did not reflect information within the case record. Documentation within the case record stated the children were born with a positive toxicology for marijuana and this was known prior to the completion of the Safety Assessment, but was not selected as a safety factor. The 7-day Safety Assessment was approved 1 day after the due date.

**Legal Reference:**

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

**Action:**

OCDSS will complete all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised. Safety Assessments will be completed and approved within the required timeframes.

[redacted]

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

There was no CPS history more than 3 years prior to the fatality.

## 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

## Additional Local District Comments

91% of all notes were entered before 30 days after the event date. 89% of all notes entered were completed within 15 days of the event date. Of the 17 notes entered more than 30 days after the event date, 10 of those notes were between June 16-June 18, 2018. There was a total of 30 notes between those dates and 67% of those notes were entered in less than 10 days after the event date. It should be noted that June 16, 2018 is when Twin B passed away and the events that occurred during those two days were extremely intense. The complexity of the situation during those two dates, including having three open reports at once for the twins (two of which being fatality reports) should be taken into consideration in the assessment of timely documentation. Otsego Co supports that the 24-hour safety assessment was accurate. At that time, some safety factors existed but did not rise to the level of immediate or impending danger. The notes state a safety plan was not developed then because the Department did not have information yet to determine that a safety plan was needed. Otsego DSS independently identified and documented that the 7-day safety assessment was inaccurate. This was noted in a June 7,2018 supervisory note. Regarding the 30-day safety assessment, it is important to emphasize the safety and risk determination of the case was correct because the safety assessments and notes both note that enough information had been gathered to determine the need and implementation of a safety plan. Although safety decision two was chosen and not safety decision three, the safety assessments and notes clearly state the safety concerns and the controlling intervention/safety plan. It is important to note that Otsego County DSS has petitions pending to be filed in Family Court against the mother and father. They have been drafted and are being reviewed by the legal department.

## 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