

**Report Identification Number: SY-20-014** 

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

**Issue Date: Aug 25, 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 <u>only</u> 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						
DrDoctor	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	ACS-Administration for Children's	NYPD-New York City Police						
Service	Services	Department						
PPRS-Purchased Preventive	TANF-Temporary Assistance to Needy	FC-Foster Care						
Rehabilitative Services	Families							
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 Jurisdiction: Onondaga Date of Death: 03/21/2020

Age: 5 month(s) Gender: Female Initial Date OCFS Notified: 03/21/2020

#### **Presenting Information**

An SCR report alleged on 3/20/20, around 11:30PM, the subject child was dropped off at the babysitter's house. The babysitter placed the child on the bed in a car seat to sleep for the night. There were three unknown children (names and ages unknown) also sleeping in the bed. The babysitter fed the child on 03/21/2020 around 3:00AM. The babysitter checked on the child on 03/21/2020 around 7:00AM and he was unresponsive. The child did not have any visible injuries. The child was otherwise healthy and there was no explanation for the child's death, making it suspicious in nature. The roles of the three unknown children, the unknown adult (name and relationship to family unknown), the mother and the father were unknown.

#### **Executive Summary**

This fatality report concerns the death of the 5-month-old female subject child that occurred on 3/21/20. The child was in the care of her aunt and adult cousin at the time of her death. A report was made to the SCR on the same date. Allegations included Inadequate Guardianship and DOA/Fatality against the aunt regarding the subject child and Inadequate Guardianship against the aunt and adult cousin regarding the adult cousin's 10-month-old and 3-year-old children and the aunt's 7-year-old and 2-year-old children. The aunt and adult cousin had open prevention cases and the aunt had an open child protective services investigation at the time the fatality investigation was received.

Onondaga County Department of Social Services (OCDSS) coordinated investigative efforts with law enforcement, and the District Attorney's Office. At the time this report was written, law enforcement had not found any criminality related to the death of the subject child. An autopsy was performed and the final report had not yet been made available to OCDSS for review. The medical examiner reported that there were no apparent prior medical issues for the subject child.

OCDSS interviewed the aunt and parents regarding the fatality. It was learned that on 3/20/20, the parents left the deceased child in the care of the aunt and adult cousin for a night of babysitting. There was a surviving sibling, age 2, who remained with the parents the night the subject child was baby sat. The subject child was put to sleep by the aunt in a car seat at an unknown time. The aunt fed the child around 3:00AM and propped a bottle in her mouth. The aunt fell asleep and when she woke around 7:00AM, she noticed the child was not breathing. The aunt called 911 and the adult cousin provided CPR to the child until first responders arrived. There were inconsistent details provided regarding where the four minor cousins slept; however, it was reported the aunt slept in the bed with at least two of the minor cousins and the subject child, who was cradled in the car seat on top of the aunt's bed.

OCDSS removed the aunt's two minor children and the adult cousins two minor children and placed them in foster care the day of the fatality. On 3/23/20, the children were returned to their mother's in family court. The aunt and adult cousin were ordered by the judge to cooperate with services through OCDSS. The allegations had not yet been determined at the time this report was completed. The aunt and adult cousin continued to have open Prevention Services cases with OCDSS. The surviving sibling remained in the care of her parents and there were no identified concerns for the family.

OCDSS missed opportunities to gather pertinent information by not completing an interview of the 7-year-old cousin, who was present at the time of the death. In addition, the aunt and the adult cousin were minimally interviewed and not asked questions about the death or safety and risk. The parents and surviving sibling were provided information regarding grief services; however, it was not documented that the aunt, adult cousin and the minor cousins were offered any supportive services following the fatality.

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#### **PIP Requirement**

This review resulted in citations related to casework practice. In response, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS will review the plan(s) and revise as needed.

#### Findings Related to the CPS Investigation of the Fatality

#### **Safety Assessment:**

- Was sufficient information gathered to make the decision recorded on the:
  - Approved Initial Safety Assessment?

Yes

Safety assessment due at the time of determination?

Unable to Determine

Was the safety decision on the approved Initial Safety Assessment Yes appropriate?

#### **Determination:**

Was sufficient information gathered to make determination(s) for The CPS report had not yet been all allegations as well as any others identified in the course of the investigation?

determined at the time this Fatality report was issued.

Was the determination made by the district to unfound or indicate Unable to Determine appropriate?

#### **Explain:**

Conversations with the aunt and adult cousins were lacking key safety and risk related questions and questions related to the fatality. OCDSS determined there were concerns that resulted in a removal of the minor cousins; however, there were no services explored or offered to mitigate those concerns.

Was the decision to close the case appropriate?

N/ANo

Was casework activity commensurate with appropriate and relevant

Was there sufficient documentation of supervisory consultation?

statutory or regulatory requirements?

Yes, the case record has detail of the

consultation.

#### **Explain:**

Appropriate services were offered to the parents and suriving sibling and there was no further need for CPS involvement. The aunt and 18-year-old cousin continued to have open prevention services at the time this report was written. Contact with the aunt and adult cousin lacked questions about safety, risk, the allegations and services.

#### **Required Actions Related to the Fatality**

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



Issue:	Adequacy of Documentation of Safety Assessments					
Summary:	The 7-day safety assessment tool was not completed.					
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)					
Action:	The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-day safety assessment in Connections.					
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians					
Summary:	Conversations with the aunt and adult cousin were lacking key safety and risk-related questions and questions about the fatality. In addition, there was no interview of the 7yo to assess overall safety and risk.					
Legal Reference:	432.1 (o)					
Action:	OCDSS will incorporate key safety and risk-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.					
Issue:	Adequacy of services following the fatality					
Summary:	It was not documented that the aunt, adult cousin and minor cousins were offered services following the fatality.					
Legal Reference:	18 NYCRR 432.2(b)(4);428.6					
Action:	OCDSS will explore areas of potential service needs with all family members with whom they are involved. OCDSS will appropriately respond to changing circumstances, and if service needs are identified, OCDSS will make the appropriate referral to preventive or community-based services in an effort to determine whether there are services that can benefit the family.					

# **Fatality-Related Information and Investigative Activities**

	Incident Information							
<b>Date of Death:</b> 03/21/2020	<b>T</b> 0	Time of Death: 08:00 AM						
Time of fatal incident, if	different than time of death:		Unknown					
County where fatality inc	cident occurred:		Onondaga					
Was 911 or local emerger	ncy number called?		Yes					
Time of Call:			Unknown					
Did EMS respond to the	scene?		Yes					
At time of incident leading	g to death, had child used alcohol	or drugs?	No					
Child's activity at time of	fincident:							
	☐ Working	Driving / Vehic	ele occupant					
☐ Playing	☐ Eating	Unknown						
Other								

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How long before incident was the child last seen by caretaker? 4 Hours					
At time of incident supervisor was:					
☐ Drug Impaired	Absent				
Alcohol Impaired					
Distracted	☐ Impaired by illness				
Impaired by disability	Other:				

Did child have supervision at time of incident leading to death? Yes

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	5 Month(s)
Deceased Child's Household	Father	No Role	Male	25 Year(s)
Deceased Child's Household	Mother	No Role	Female	23 Year(s)
eceased Child's Sibling No Role ousehold		Female	2 Year(s)	
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Female	35 Year(s)
Other Household 1	Other Adult - Cousin	Alleged Perpetrator	Female	18 Year(s)
Other Household 1	Other Child - Cousin	Alleged Victim	Male	7 Year(s)
Other Household 1	Other Child - Cousin	Alleged Victim	Male	2 Year(s)
Other Household 1	Other Child - Cousin	Alleged Victim	Female	10 Month(s)
Other Household 1	Other Child - Cousin	Alleged Victim	Male	3 Year(s)
Other Household 3	Other Adult - Father of 3-year-old cousin	No Role	Male	26
Other Household 4	Other Child - Father of 2-year-old and 10-month-old cousins	No Role	Male	17 Year(s)
Other Household 5	Other Adult - Father of 7-year-old cousin	No Role	Male	41 Year(s)

#### LDSS Response

Upon receipt of the SCR report on 3/21/20, OCDSS initiated their investigation and coordinated efforts with law enforcement, notified the District Attorney's Office, contacted the medical examiner and spoke to the source. OCDSS learned the subject child was in the care of a maternal aunt and 18-year-old cousin at the time of her death. OCDSS assessed the safety of the aunt and adult cousin's children, ages 7-years, 3-years, 2-years and 10 months, and determined an emergency placement in foster care was necessary for their safety. There was a 2-year-old surviving sibling who was in the care of her mother and father at the time of the death. OCDSS determined she was safe and remained in the care of her

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parents.

OCDSS gathered information from first responders. Upon arrival to the scene, the fire department observed the aunt leaning over the subject child and she was prompted multiple times to move aside. The child was observed to have blue lips and was without a pulse. The fireman heard EMS arriving and ran the subject child to be transported to the hospital. EMS also reported that the child was ran out to the ambulance and was not alive upon their arrival.

The aunt was briefly interviewed and reported that the night of 3/20/20, she, her two minor children and the subject child slept in her queen size bed together. The subject child was placed in her car seat on top of the bed. The 18-year-old cousin slept in a separate room in a twin-size bed with her two children. The 18-year-old cousin was not interviewed regarding the death.

The mother and father were interviewed together. The mother reported that the aunt had offered to watch the subject child and the mother agreed. The mother dropped the child off at the aunt's home at 11:45AM. The mother reported she was told by the aunt there was a "baby chair" for the child to sleep in. The parents were questioned about safe sleep guidelines, which they were both aware of, and reported they typically practiced it with their children. On 3/21/20 around 7:30AM, the mother and father were notified the subject child was brought to the hospital where she was eventually pronounced deceased. The parents reported they were provided details of the events leading up to the child's death by the aunt. The parents stated that the aunt propped a bottle in child's mouth at approximately 3:00AM and fell asleep until approximately 7:00AM. The aunt noticed the child not breathing, brought her into the 18-year-old cousins' room, and called 911 while the cousin performed CPR until first responders arrived.

OCDSS briefly interviewed the father of the 3-year-old and 10-month-old cousins. He was in Juvenile Detention and had phone contact with his children. The father of the 2-year-old cousin was briefly interviewed via telephone as well. He reported he had video calls with his child. Neither of these father's were asked about any concerns they had for the care of their children with the mothers. The father of the 7-year-old cousin was not interviewed.

OCDSS appeared in court and requested a continued removal of the four minor cousins. The judge denied this and ordered that the children be returned to their mothers. The judge further ordered that the aunt and 18-year-old cousin practice safe sleep guidelines, not care for any children other than their own, not fight in the presence of the children, cooperate with visits by OCDSS and not use drugs or alcohol in the presence of their children.

OCDSS offered the parents grief counseling services and a book on grief was provided to the surviving sibling. There were no services offered to the aunt, adult cousin or minor cousins. The CPS investigation case remained open at the time this report was completed. The aunt and adult cousin had cases that remained open with prevention services.

#### 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

**Comments:** OCDSS notified the District Attorney's Office and collaborated with law enforcement regarding the

fatality.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

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**Comments:** Onondaga County indicated in their 24-hour and 30 day fatality reports that the fatality would be submitted to their county's CFRT.

#### **SCR Fatality Report Summary**

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053675 - Deceased Child, Female, 5 Mons	053679 - Aunt/Uncle, Female, 35 Year(s)	DOA / Fatality	Pending
053675 - Deceased Child, Female, 5 Mons		Inadequate Guardianship	Pending
053681 - Other Child - Cousin, Male, 7 Year(s)		Inadequate Guardianship	Pending
053682 - Other Child - Cousin, Male, 2 Year(s)	053679 - Aunt/Uncle, Female, 35 Year(s)	Inadequate Guardianship	Pending
053683 - Other Child - Cousin , Female, 10 Month(s)		Inadequate Guardianship	Pending
053684 - Other Child - Cousin , Male, 3 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?	$\boxtimes$			
All appropriate Collaterals contacted?		$\boxtimes$		
Emergency Room Personnel				
School		$\boxtimes$		
Pediatrician		$\boxtimes$		
Was a death-scene investigation performed?	$\boxtimes$			
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?	$\boxtimes$			
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?	$\boxtimes$			
Was there an adequate assessment of impending or immediate danger to s household named in the report:	urviving	siblings/o	ther child	dren in the
Within 24 hours?	$\boxtimes$			
At 7 days?	$\boxtimes$			
At 30 days?	$\boxtimes$			
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	$\boxtimes$			
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 I	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?		$\boxtimes$		
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?		$\boxtimes$		
Were appropriate/needed services offered in this case		$\boxtimes$		
Explain: There were no conversations with the aunt and adult cousin about additional see in response to the fatality and the concerns that led to the temporary removal of the temporary removal of the were no additional services provided to the aunt, adult cousin or minor concerns enumerated in the investigation.	f their chi	ldren.		•

#### **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?				



Mental health services

# **Child Fatality Report**

	urviving children in the hou this fatality report / investi y?							
If Yes, court ordered?								
Explain as necessary:  OCDSS removed the children of the aunt and the 18-year-old cousin. The children were later returned to their mothers in family court. The surviving sibling remained in the care of his parents.								
		Legal Activ	rity Related t	to the Fatality	V			
					<i>y</i>			
<b>Was there leg</b> ⊠Family Cou	al activity as a result of the	<b>fatality inv</b> Criminal C	_	?	□Ord	ler of Prote	ection	
Family Cour	t Petition Type: FCA Articl	e 10 - CPS						
Date Filed:	<b>Fact Finding Description:</b>			Disposit	tion Descr	ription:		
03/23/2020	There was not a fact finding	9		There w	as not a di	sposition		
Respondent:	053679 Aunt/Uncle Female	35 Year(s)						
<b>Comments:</b>	On 3/21/20 OCDSS remove OCDSS requested a continuand returned the children to	ıed removal		•				•
-	t Petition Type: FCA Articl			<u> </u>				
Date Filed:	Fact Finding Description:				tion Descr	-		
03/23/2020	There was not a fact finding			There w	as not a di	sposition		
Respondent:	053680 Other Adult Female	e 18 Year(s)	)					
Comments:	On 3/21/20 OCDSS removes the fatality. OCDSS request removal and returned the ch	ted a contin	ued remova	ıl in family c				
	Services F	rovided to t	he Family in	Response to	the Fatality	у		
		Provided	Offered,	Offered,		Needed		CDR
	Services	After Death	but Refused	Unknown if Used	Not Offered	but Unavailal	N/A	Lead to Referral
Bereavement	counseling							
Economic sup	pport			$\boxtimes$				
Funeral arra	ngements				$\boxtimes$			
Housing assistance								

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and variny services			) == <b>\f</b>				
Foster care							
Health care						$\boxtimes$	
Legal services						$\boxtimes$	
Family planning						$\boxtimes$	
Homemaking Services						$\boxtimes$	
Parenting Skills						$\boxtimes$	
<b>Domestic Violence Services</b>						$\boxtimes$	
<b>Early Intervention</b>				$\boxtimes$			
Alcohol/Substance abuse				$\boxtimes$			
Child Care						$\boxtimes$	
Intensive case management						$\boxtimes$	
Family or others as safety resources						$\boxtimes$	
Other						$\boxtimes$	
Explain: The parents were provided with a book on grief for the surviving sibling. It is not documented that the cousins were provided with services in response to the fatality.  Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes  Explain: The parents were offered grief counseling. It is not documented that the aunt and adult cousin were provided with services in response to the fatality.							
	History	Prior to t	he Fatality	y			
			•				
	C	hild Inform	ation				
Did the child have a history of alleged child abuse/maltreatment?  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				

Was not noted in the case record to have any of the issues listed

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Had heavy alcohol use

Smoked tobacco

Used illicit drugs

**During pregnancy, mother:** 

Experienced domestic violence

Had medical complications / infections

☐ Misused over-the-counter or prescription drugs



Infant was born:	
Drug exposed	☐ With fetal alcohol effects or syndrome
With neither 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)
03/10/2020	Other Child - Cousin , Male, 7 Years	Aunt/Uncle, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	Yes

#### Report Summary:

An SCR report alleged that the 7-year-old cousin had access to guns and knives. The 7-year-old stayed up all night with a gun to protect the home. The aunt failed to properly secure the guns and knives in the home.

Report Determination: Unfounded Date of Determination: 04/03/2020

#### **Basis for Determination:**

OCDSS determined the allegation of IG was unsubstantiated, as there was no credible evidence discovered throughout their investigation. OCDSS interviewed the 7-year-old cousin, the aunt and collaterals, and there was no information provided to indicate the allegation.

#### **OCFS Review Results:**

OCDSS contacted the source, entered timely progress notes, contacted several collaterals and conducted a CPS history check. OCDSS did not interview one of the adults who resided in the home and was identified as the secondary caretaker on the RAP. The 7-day safety assessment was not documented in Connections until two weeks after the receipt of the SCR report. Notification letters were not sent until two weeks after the receipt of the SCR report. The fathers of the children were identified and notified of the SCR report in writing; however, there was no documented efforts of additional contact with them.

Are there Required Actions related to the compliance issue(s)? $ extstyle \geq$	∐Yes	Nc

#### Issue:

Timely/Adequate Seven Day Assessment

#### Summary:

The 7-day safety assessment tool was not completed in Connections until two weeks after the receipt of the SCR report.

#### Legal Reference:

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

#### Action:

OCDSS will document and approve all safety assessments within the required time frame.

#### **PIP Requirement:**

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

#### Issue:

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

#### Summary:

It was not documented that a comprehensive interview was completed with the 18-year-old cousin, who was listed on the investigation and resided in the home.

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#### Legal Reference:

432.1 (o)

#### Action:

OCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean 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:**

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

	Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Outcome	Compliance Issue(s)
C	5/09/2019	Other Child - Cousin , Female, 2 Days	Other - Cousin , Female, 17 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

#### Report Summary:

An SCR report alleged that the then 17-year-old cousin gave birth to a baby on 5/7/19. The baby tested positive for marijuana. There were concerns for the baby due to the 17-year-old's age. The aunt and the two 2-year-old cousins had unknown roles.

**Report Determination:** Unfounded **Date of Determination:** 06/06/2019

#### **Basis for Determination:**

OCDSS unsubstantiated the allegations of PDRG and stated there was no impact on the baby. The then 17-year-old cousin denied drug use and the hospital did not provide a statement of negative impact on the baby.

#### **OCFS Review Results:**

OCDSS adequately assessed the safety of the maltreated child within 24 hours. They spoke to the source, made a home visit, discussed a plan of safe care and reviewed safe sleep with the then 17-year-old cousin. There were multiple collateral contacts made with service providers. The other minor cousins, who were in foster care at the time of the SCR report, were all assessed for safety within 24 hours. The assessments, notes, RAP and investigation were completed in a timely manner and appropriate determinations were made; however, there were no notifications letters sent.

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

#### Issue:

Failure to provide notice of report

#### Summary:

Three of the adults on the investigation were not notified of the SCR report in writing.

#### Legal Reference:

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

#### Action:

ODSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

#### PIP Requirement:

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



Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/14/2018	Other Child - Cousin , Male, 1 Years	Aunt/Uncle, Female, 34 Years	Inadequate Guardianship	Substantiated	Yes
	Other Child - Cousin , Male, 1 Years	Aunt/Uncle, Female, 34 Years	Lack of Supervision	Substantiated	
	Other Child - Cousin , Male, 1 Years		Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other - Cousin , Female, 17 Years	Aunt/Uncle, Female, 34 Years	Childs Drug / Alcohol Use	Substantiated	
	Other - Cousin , Female, 17 Years	Aunt/Uncle, Female, 34 Years	Inadequate Guardianship	Substantiated	
	Other - Cousin , Female, 17 Years	Aunt/Uncle, Female, 34 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Other Child - Cousin , Male, 6 Years		Inadequate Guardianship	Substantiated	
	Other Child - Cousin , Male, 6 Years	Aunt/Uncle, Female, 34 Years	Lack of Supervision	Substantiated	
	Other Child - Cousin , Male, 6 Years	Aunt/Uncle, Female, 34 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Other Child - Cousin , Male, 1 Years	Aunt/Uncle, Female, 34 Years	Inadequate Guardianship	Substantiated	
	Other Child - Cousin , Male, 1 Years	Aunt/Uncle, Female, 34 Years	Lack of Supervision	Substantiated	
	Other Child - Cousin , Male, 1 Years	1	Parents Drug / Alcohol Misuse	Unsubstantiated	

#### Report Summary:

An SCR report alleged that the aunt engaged in physical altercations in the presence of the then 17yo cousin, unrelated 15yo, two 1yo cousins and 5yo cousin. On 12/12/18, the aunt got into a physical altercation with another adult on a public bus while two of the cousins were present. The aunt was arrested and incarcerated and did not make an appropriate plan for the cousins. The aunt left the 17yo cousin in charge of the other cousins. The 17yo had a history of getting in trouble. The aunt allowed the 17yo to drink and use marijuana in the home. The aunt used marijuana and drank alcohol to the point of intoxication while being the sole caretaker for the cousin

**Report Determination:** Indicated **Date of Determination:** 01/07/2019

#### **Basis for Determination:**

The aunt was arrested and put in jail for assaulting two people on a public bus. The aunt was called to the bus station and engaged in physical violence with the then 1yo cousin present. A stranger held the 1yo while the violence occurred. While in jail, the aunt had a relative stay at her home with the cousins and agreed to let OCDSS go to the home. When OCDSS arrived, the relative denied access to the home and an access order was granted. When OCDSS returned to the home, the aunt and then 17yo cousin were hostile toward caseworkers and unwilling to address any concerns. Interviews with the then 5yo revealed significant CPS concerns and the all the cousins were removed except the 17yo.

#### **OCFS Review Results:**

OCDSS conducted a timely investigation and contacted appropriate collaterals. During the investigation, a relative indicated she resided in the home; however, was not added to the investigation. The father of one of cousins was not added to the investigation. NOE letters were not sent to all the adults. The investigation conclusion referred to concerns

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with the condition of the home, but the RAP does not. OCDSS requested a removal of the cousins, which was granted by the Judge; however, the removed cousins were then left in the home for a night with their mothers due to issues with transportation.

Are there Required Actions related to the compliance issue(s)? \( \subseteq Yes \) \( \subseteq No

#### **Issue:**

Contact/Information From Reporting/Collateral Source

#### Summary:

A relative was identified as residing in the home and was not added to the investigation, interviewed or notified of the SCR report in writing. As a result, there were missed opportunities to gather information.

#### Legal Reference:

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

#### Action:

OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

#### **PIP Requirement:**

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

#### Issue:

Failure to provide notice of report

#### Summary:

OCDSS did not provide Notice of Existence letters to two of the fathers or make effort to speak with them about the report.

#### Legal Reference:

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

#### Action:

OCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice

#### **PIP Requirement:**

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

#### Issue:

Overall Completeness and Adequacy of Investigations

#### Summary:

OCDSS went to family court and obtained a Removal Order of the children; however, when the plan for transportation failed, the children were left in the home with their mothers for the night.

#### Legal Reference:

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

#### Action:

OCDSS will review and adhere to regulations regarding casework practice. OCDSS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

#### PIP Requirement:



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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/14/2018	Other - Father to cousin , Male, 15 Years	I/VO IS VO ISVO I/VO Hemale /III	Inadequate Guardianship	Substantiated	Yes
	Other - Father to cousin , Male, 15 Years	Duo 13 vo 15vo 17vo Hemale /III	Lacerations / Bruises / Welts	Substantiated	
	Other - Father to cousin , Male, 15 Years	Other Adult - Mother to 2yo,13,yo,15yo,17yo, Female, 40 Years	Sexual Abuse	Unsubstantiated	
	Other - Father to cousin , Male, 15 Years	Other Adult - Father to 15yo and 13yo, Male, 41 Years	Inadequate Guardianship	Substantiated	
	Other - Father to cousin , Male, 15 Years	Other Adult - Father to 2yo, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Other - Cousin , Female, 16 Years	Aunt/Uncle, Female, 34 Years	Inadequate Guardianship	Substantiated	
	Other - Cousin , Female, 16 Years	Aunt/Uncle, Female, 34 Years	Sexual Abuse	Unsubstantiated	
	Other - Father to cousin , Male, 15 Years	/\lint/  ncia Hamaia 4/  Vaare	Inadequate Guardianship	Substantiated	
	Other - Father to cousin , Male, 15 Years	Aunt/Uncle, Female, 34 Years	Sexual Abuse	Unsubstantiated	

#### Report Summary:

An SCR report alleged that the aunt allowed the then 16-year-old cousin and her 15-year-old boyfriend to engage in a sexual relationship and they had a child as a result. The aunt was aware of the ongoing sexual relationship and failed to intervene.

**Report Determination:** Indicated **Date of Determination:** 11/29/2018

#### **Basis for Determination:**

The aunt admitted to having knowledge that the then 16-year-old and the 15-year-old were engaged in a sexual relationship. The aunt was educated on NYS law regarding consent. Despite being provided that information, the aunt reported she would continue to allow the children to have sex because they already had a child together. The 15-year-old continued to stay at the home and slept in the same bed as the 16-year-old. OCDSS filed a neglect petition against the aunt and opened the family to preventive services.

#### **OCFS Review Results:**

OCDSS spoke to the source and documented a history check. The 7-day safety assessment was completed 16 days after intake and was incomplete. OCDSS made contact with the family within the first 7 days; however, the children in the

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aunt's home were not seen or interviewed until a month after the report was received. Concerns of drug misuse and excessive discipline were reported during an interview with one of the cousins, which were never addressed with the aunt.

Are there Required Actions related to the compliance issue(s)? \( \subseteq Yes \) \( \subseteq No

**Issue:** 

Timely/Adequate Seven Day Assessment

Summary:

The 7-day safety assessment tool was not completed on time.

Legal Reference:

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

Action:

OCDSS will document and approve all safety assessments within the required timeframe.

#### **PIP Requirement:**

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

Issue:

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

#### Summary:

Concerns regarding physical discipline and drug and alcohol misuse were reported during an interview with one of the children and were not addressed during casework contacts with the parent.

#### Legal Reference:

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

#### Action:

In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. OCDSS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

#### **PIP Requirement:**

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

#### Issue:

Adequacy of Risk Assessment Profile (RAP)

#### Summary:

The secondary caretaker identified in the RAP reported having depression during an interview and this is not accurately reflected in the tool.

#### Legal Reference:

18 NYCRR 432.2(d)

#### Action:

OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

#### **PIP Requirement:**

For issues identified in historical cases, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issue(s). For

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issues where a PIP is currently implemented, OCDSS will review the plan and revise as needed to address ongoing concerns.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/30/2018	l '	Other - Cousin , Female, 16 Years	Inadequate Guardianship	Substantiated	Yes
		Other - Cousin , Female, 16 Years	Lack of Supervision	Unsubstantiated	
	1	Other - Cousin , Female, 16 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Other Child - Cousin , Male, 5 Years	Aunt/Uncle, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	1	1	Parents Drug / Alcohol Misuse	Unsubstantiated	
		Aunt/Uncle, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Cousin , Male, 1 Years	Aunt/Uncle, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Cousin , Male, 1 Years	Aunt/Uncle, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Cousin , Male, 1 Years	Aunt/Uncle, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

#### Report Summary:

An SCR report alleged that the then 16-year-old cousin used marijuana to the point of impairment and was unable to provide a minimum degree of care for her then 1-year-old child. The then 16-year-old cousin left her child unsupervised and left the home to buy marijuana. There was no food in the home and the 1-year-old missed meals. The 1-year-old lost weight as a result. The father of the 1-year-old cousin had an unknown role.

**Report Determination:** Indicated **Date of Determination:** 12/13/2018

#### **Basis for Determination:**

The allegations of IG and PDRG against the then 16-year-old cousin were substantiated. OCDSS interviewed the then 5-year-old cousin who reported detailed knowledge about the 16-year-old's marijuana use. LSUP against the then 16-year-old cousin was unsubstantiated because OCDSS reported there was no evidence that the then 1-year-old cousin was not supervised by an adult. OCDSS unsubstantiated the allegations of IG and PDRG against the aunt and reported this was because they had already substantiated the allegations in another report where the aunt where she was identified as the caretaker.

#### **OCFS Review Results:**

OCDSS completed a history check and completed the RAP accurately. OCDSS did not adequately assess for safety of the maltreated children within 24 hours. There was no contact made with the family until 2 weeks after the report date. There was no 7-day safety assessment tool completed. Two of the fathers were not added to the investigation. There was no notification letter sent to the absent father who was listed on the investigation. All of the progress notes were entered 2-5 months after their event date. The determination made against the aunt was not appropriate.

Are there Required Actions related to the compliance issue(s)? Yes No	
Issue:	
Timely/A degree 24 Hove Aggegment	

Timely/Adequate 24 Hour Assessment

Summary:

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Although attempts were made to accomplish contact with the family within the first 24 hours of the receipt of the report, there were no other attempts made to assess for safety until 8/6/18. There was no attempted contact documented with collaterals who could have assisted in establishing safety of the children within the first 24 hours.

#### Legal Reference:

SSL 424(6);18 NYCRR 432.2(b)(3)(i)

#### Action:

OCDSS will adequately assess safety of children respective to case circumstances within 24 hours of each SCR report.

#### **PIP Requirement:**

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

#### Issue:

Adequacy of Documentation of Safety Assessments

#### Summary:

OCDSS did not complete the 7-day safety assessment tool.

#### Legal Reference:

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

#### Action:

The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-day safety assessment in Connections.

#### **PIP Requirement:**

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

#### Issue:

Timely/Adequate Case Recording/Progress Notes

#### **Summary:**

All progress notes in the investigation were entered several months after their event date.

#### Legal Reference:

18 NYCRR 428.5

#### Action:

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

#### **PIP Requirement:**

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

#### Issue:

Failure to provide notice of report

#### Summary:

It was not documented that the fathers of the children were provided with written notice of the report.

#### Legal Reference:

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

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#### Action:

OCDSS 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.

#### **PIP Requirement:**

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

#### Issue:

Failure to Provide Notice of Indication

#### Summary:

There was no documentation that the fathers of the children were notified in writing of the indicated report.

#### Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

#### Action:

If an SCR report is indicated the LDSS must delivers 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 seven days of the determination, in such form as required by OCFS.

#### **PIP Requirement:**

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

#### Issue:

Appropriateness of allegation determination

#### Summary:

OCDSS unsubstantiated the allegations against the aunt on this investigation, despite there being some credible evidence gathered to indicate them. OCDSS supported this by stating they had another investigation open with the aunt listed as the caretaker and substantiated against her in that investigation, which is an insufficient narrative to support the determination.

#### Legal Reference:

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

#### Action:

OCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s). OCDSS will consult with the Syracuse Regional Office if technical assistance is required when determining the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/13/2018	Other - Cousin , Female, 16 Years	Aunt/Uncle, Male, 47 Years	Inadequate Guardianship		
	Other Child - Cousin , Male, 1 Years	Aunt/Uncle, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Cousin , Male, 1 Years	l ' '	Parents Drug / Alcohol Misuse	Unsubstantiated	



Other Child - Cousin , Male, 5 Years	Aunt/Uncle, Female, 33 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Cousin , Male, 1 Years	Aunt/Uncle, Female, 33 Years	Inadequate Guardianship	Unsubstantiated
Other - Cousin , Female, 16 Years	Aunt/Uncle, Female, 33 Years	Childs Drug / Alcohol Use	Unsubstantiated
Other - Cousin , Female, 16 Years	Aunt/Uncle, Female, 33 Years	Excessive Corporal Punishment	Substantiated
Other - Cousin , Female, 16 Years	Aunt/Uncle, Female, 33 Years	Inadequate Guardianship	Substantiated
Other - Cousin , Female, 16 Years	Aunt/Uncle, Female, 33 Years	Internal Injuries	Unsubstantiated
Other - Cousin , Female, 16 Years	Aunt/Uncle, Female, 33 Years	Lacerations / Bruises / Welts	Substantiated
Other - Cousin , Female, 16 Years	Aunt/Uncle, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other - Cousin , Female, 16 Years	Aunt/Uncle, Female, 33 Years	Sexual Abuse	Unsubstantiated

#### Report Summary:

An SCR report alleged that on 6/13/18, as a form of punishment, the aunt punched the then 16-year-old cousin in the eye because the cousin failed to clean the home. As a result, the cousin sustained a laceration to her right eye, which required stitches. The cousin bled from the right eye. The uncle was present during the incident and failed to intervene. The then 1-year-old cousin was present for the incident, but was not injured. The aunt and then 16-year-old cousin have had physical altercations in the past.

Report Determination: Indicated Date of Determination: 09/20/2018

#### **Basis for Determination:**

OCDSS obtained police records regarding the incident. The aunt admitted that she punched the 16-year-old cousin in her statement. The aunt was arrested for assault and endangering the welfare of a child. The police were able to observe the injuries to the cousin's face. The then 16-year-old cousin would not cooperate with CPS and was not interviewed.

#### OCFS Review Results:

OCDSS called the source, completed a history check and completed the RAP on time and accurately. OCDSS did not complete a 7-day safety assessment. The aunt was not interviewed until a month after the receipt of the report. Two of the minor cousins were never interviewed. The father to one of the cousins was not added to the investigation or notified of the report. The other absent fathers were added and notified in writing, but no effort was made to have further discussions with them. NOE letters were not mailed until 8/20/18. There were numerous notes entered more than a month after their event date.

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

#### Issue:

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

#### **Summary:**

Two of the minor cousins were not interviewed during the investigation. The father of one of the cousins was identified; however, he was not added to the investigation and there were no documented efforts to interview him or barriers in doing so.

#### Legal Reference:

432.1 (o)

Action:



OCDSS will make efforts in interviewing all children on the investigation and parents/absent parents of those children.

### PIP Requirement:

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

#### Issue:

Adequacy of Documentation of Safety Assessments

#### Summary:

The 7-day safety assessment tool was not completed for this investigation.

#### Legal Reference:

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

#### Action:

The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-day safety assessment in Connections.

#### **PIP Requirement:**

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

#### Issue:

Timely/Adequate Case Recording/Progress Notes

#### Summary:

Multiple progress notes were not entered contemporaneously during the investigation, and were documented more than a month after their event date.

#### Legal Reference:

18 NYCRR 428.5

#### Action:

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

#### **PIP Requirement:**

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/05/2017	Other Child - Cousin , Female, 15 Years	Aunt/Uncle, Female, 32 Years	Inadequate Guardianship	Substantiated	Yes
1	Other Child - Cousin , Female, 15 Years	l ' '	Lacerations / Bruises / Welts	Substantiated	
1	Other Child - Cousin , Female, 15 Years	1	Parents Drug / Alcohol Misuse	Unsubstantiated	



· · · · · · · · · · · · · · · · · · ·	Aunt/Uncle, Female, 32 Years	Swelling / Dislocations / Sprains	Substantiated
Other Child - Cousin , Male, 4 Months	Aunt/Uncle, Female, 32 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Cousin , Male, 4 Months	Aunt/Uncle, Female, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

#### Report Summary:

An SCR report alleged that on 6/14/17, the aunt got in an argument with the then 15-year-old cousin. The argument escalated to physical violence when the aunt punched the cousin on the face, and inflicted bruising and swelling to the cousin's eye. The cousin also sustained a hemotoma. The aunt then kicked the cousin and the cousin's 4-month-old child out of the home without making a plan for their care.

Report Determination: Indicated Date of Determination: 08/29/2017

#### **Basis for Determination:**

The then 15-year-old cousin was observed by CPS with swelling and bruising to her eye. There were two witnesses to the altercation who reported the cousin and aunt fought, the cousin got in the aunt's face and the aunt responded by punching the cousin in the face. The aunt was charged with assault and endangering the welfare of a child. The 15-year-old was placed in respite care with her 4-month-old child.

#### **OCFS Review Results:**

OCDSS called the source, completed a history check and conducted home visits. OCDSS did not complete the 7-day safety assessment until 7/27/17. The fathers of the cousins were identified; however, there were no documented efforts to speak with them. The RAP was not completed accurately. Safe sleep information was not provided to the 15yo cousin regarding her 4mo child. Appropriate services were not offered. It was not clearly documented the method in which the cousin and her child were put into respite care and an FSS was opened, as there is no evidence of a conversation with the aunt about this plan. There were numerous notes completed more than a month after their event date.

Are there Required Actions related to the compliance issue(s)? \( \subseteq \text{Yes} \) \( \subseteq \text{No} \)

#### Issue:

Timely/Adequate Case Recording/Progress Notes

#### Summary:

Several progress notes were not entered contemporaneously during the investigation and were documented a month after their event date.

#### Legal Reference:

18 NYCRR 428.5

#### Action:

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

#### **PIP Requirement:**

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

#### Issue:

Adequacy of Risk Assessment Profile (RAP)

#### Summary:

Although the Risk Assessment Profile was completed, it was recorded that there was no elevated risk. One of the children was injured as a result of abuse/maltreatment by the parent and required emergency medical care.

#### Legal Reference:

18 NYCRR 432.2(d)

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#### Action:

OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

#### **PIP Requirement:**

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

#### **Issue:**

Timely/Adequate Seven Day Assessment

#### Summary:

The 7-day safety assessment tool was not recorded in Connections until 7/27/17.

#### Legal Reference:

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

#### Action:

OCDSS will document and approve all safety assessments within the required time frame.

#### **PIP Requirement:**

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

#### Issue:

Failure to provide safe sleep education/information

#### Summary:

Although information on safe sleep guidelines was provided to the aunt, it was not documented that information on safe sleep guidelines was provided to then 15-year-old cousin, who had a child under the age of 1.

#### Legal Reference:

13-OCFS-ADM-02

#### Action:

OCDSS will provide information on sleep safety to the parents and caretakers of infants and expecting mothers whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

#### **PIP Requirement:**

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

#### Issue:

Failure to offer services

#### Summary:

The investigation was closed with a safety decision 3 and there were no services offered to the aunt to address the safety concerns identified at case closure.

#### Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

#### Action:



Based on the investigation and evaluation conducted, OCDSS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

#### PIP Requirement:

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

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

There was no known history more than three years prior to the fatality.

#### **Known CPS History Outside of NYS**

There was no known CPS history outside of NYS.

#### **Preventive Services History**

After a protective removal of the 7-year-old cousin, 3-year-old cousin and 2-year-old cousin in December 2018, the children were returned to their mothers in August 2019. The mothers continued to receive preventive services to monitor their court ordered services. These services included mental health treatment, substance abuse counseling, parent aide services and batterers counseling. At the time this report was written, the aunt had completed her court ordered services; however, her Prevention Services case remained open. The adult cousin continued to have her engagement in services monitored by OCDSS and her Prevention Services case remained open.

#### **Foster Care Placement History**

In December 2018, the now 7-year-old cousin, 3-year-old cousin and 2-year-old cousin were removed from the aunt and 18-year-old cousin and placed in foster care. OCDSS filed neglect petitions against the aunt and adult cousin due to concerns of violence, untreated mental health and substance abuse. In May 2019, the now 10- month-old cousin was born and remained in the adult cousin's care. OCDSS had a visiting nurse through Healthy Families put into place for the family. In August 2019, the three minor cousins were returned to their mothers and the family continued to receive direct prevention services.

#### Legal History Within Three Years Prior to the Fatality

### Was there any legal activity within three years prior to the fatality investigation?

⊠Family Court	Criminal Court	Order of Protection
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Family Court Petition Type: FCA Article 10 - CPS			
<b>Date Filed:</b>	Fact Finding Description:	Disposition Description:	
10/29/2018	Adjudicated Neglected	Order of Supervision	
Respondent:	053679 Aunt/Uncle Female 35 Year(s)		
Comments:	OCDSS filed a neglect against the aunt on 10/29/18. OCDSS then requested a removal of the then 6yo cousin and 1yo cousin on 12/18/18, which was granted. The then 6yo went to live with his father and the then 1yo went into relative foster care. The 6yo was removed from his father on 1/14/19 due to		

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4	CPS concerns and went to relative foster care with his sibling. The aunt made admissions to neglect on $4/29/19$ and was court ordered services. The then 6yo cousin and 1yo cousin were returned to the aunt on $8/6/19$ .
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Family Court Petition Type: FCA Article 10 - CPS			
Date Filed:	Fact Finding Description:	<b>Disposition Description:</b>	
12/19/2018	Adjudicated Neglected	Suspended Judgment	
Respondent:	053680 Other Adult Female 18 Year(s)		
Comments:	OCDSS filed a neglect against the adult cousin on 12/19/18 and requested a removal of the then 1yo cousin, which was granted. The then 1yo went into relative foster care. The adult cousin made admissions to neglect on 5/28/19. The adult cousin gave birth to the now 10-month-old cousin on 5/14/19 and she remained in the care of the adult cousin. The 1yo cousin was returned to the adult cousin on 8/6/19 with a 1 year Order of Supervision.		

#### **Additional Local District Comments**

We agree with the facts of the draft and recognize that a 7 day safety assessment was not submitted, conversations with the aunt and adult cousins were lacking, and that services should have been offered to surviving minor cousins, aunt, and adult cousin on this case. The caseworker on this case is addressing these issues.

#### **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