Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-18-030

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

Issue Date: Oct 17, 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: 5 month(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 04/04/2011
Initial Date OCFS Notified: 05/09/2018

Presenting Information

An SCR report alleged on an unknown date and time in 2010, the SC passed away as an infant, as a result of being suffocated. The SC was under the supervision of her PGM. No other adults were in the home at the time, making the PGM the sole caregiver. The SC was placed in a bed to sleep by an unknown person, and the PGM found the SC sometime later, not breathing. PGM left the home with the SC to get help to revive her.

There were also current alleged concerns for children in the home, some who were alive at the time of the fatality and some who were born after. The report further alleged the home was in deplorable conditions and posed a safety hazard for 5 children ranging in age from 2 to 14 years old. The adults allegedly used marijuana, and the children had access to the drugs. There were also alleged drug sales from the home in the presence of the children. The alleged subjects of the report were SC's PGM, PA, PU, and adult cousins (7 total alleged subjects).

Executive Summary

This fatality report concerns the death of a child who was 5 months old at the time of her death (SC). In 2011, the SC was receiving Preventive Services from Orange County Department of Social Services (OCDSS) and died that year while the case was open. At that time, OCDSS was notified of the death, which was said to have occurred while in the care of her PGM, who discovered her face down and unresponsive. OCFS issued an Individual Child Fatality Report on 8/24/12.

An SCR report was received by OCDSS on 5/9/18, which newly alleged SC’s PGM was responsible for her death. OCDSS initiated an investigation of the fatality and promptly addressed current, unrelated concerns.

According to the autopsy report received by OCDSS, the primary cause of death was, "Septic shock and bronchopneumonia." Several contributory causes were noted: "Prematurity with maternal history of crack abuse," "laid to sleep prone on soft bedding," and, "history of respiratory difficulties." The manner was undetermined. It was noted the SC had been found deceased face down in a waterbed after being placed there by PGM.

Along with assessing the immediate safety of the children named in the report, OCDSS coordinated with LE, as it was known they had previously investigated the death. LE relayed their case had been closed without an arrest on 8/10/11 after learning the autopsy results, and they would not conduct another investigation. As the cause of death had been medical in nature, there was never any arrest related to the fatality.

OCDSS promptly responded when concerns arose for other children named in the report, which in nature were unrelated to the fatality. OCDSS facilitated a protective removal of one child in the home, and devised a safety plan for the 2 others.

The BM had 2 additional children who were ages 5 and 6 at the time of the fatality. It was apparent from historical records that BM had not cared for them after their BF moved out of state with them in 2006. OCDSS spoke with their BF in an assessment of the siblings’ safety; it was evident they had no contact with the SC between the time of her birth and the time of her death, and they were deemed safe. It was also evident BM did not care for the SC following her birth.

Given the information gathered during the investigation, OCDSS unsubstantiated the fatality-related allegations against PGM; however, the case was IND with regard to the child who was removed and her parents. OCDSS continued involvement with that family in the form of Foster Care/CPS Services. No concerns presented regarding the 8yo sibling in

the care of BF, nor for the adult sibling's child.

The "Household Composition" section of this report notes the family members' ages and places of residence at the time of the 2018 SCR report, given the substantial amount of time since the fatality and the additional children listed. The household composition at the time of the fatality included the SC, 2 siblings, BF, PGM, and an aunt, uncle and cousin.

In the time between the fatality and the recent report, there were several cases concerning family members listed in this fatality report. During OCFS review, 2 practice issues were found to be recurring: Failing to provide Notice of Existence letters to other persons named in the report and/or biological fathers, and failing to interview necessary parties: Other persons named in the report, other persons living in the home, and/or biological fathers. During this time there were also 2 instances of improper usage of an "Out-of-Town Inquiry," as opposed to utilizing a Family Services Intake as a means of assessing and referring for Preventive Services. Another substantial concern was the 2011 Preventive case record contained no documentation pertaining to discussions with the family or collaterals about the fatality which occurred while the case was open, aside from requesting medical records. These issues have been referred to the Spring Valley Regional Office.

PIP Requirement

Practice issues were found in the historical cases within the 3 years prior to the fatality. Due to the substantial amount of time that has passed, OCFS consulted with the Spring Valley Regional Office (SVRO) regarding issues which have been addressed, issues which are still being worked on, and issues which may need further consideration. If necessary, OCDSS will submit a PIP to the SVRO within 30 days of receipt of this report, identifying 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.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
Based on evidence gathered and documented during this investigation, the determination was appropriate. All required safety assessments were timely and accurate.

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 investigation was determined and closed appropriately. The case was opened for Preventive Services for some of the children listed. There were multiple families on this case and not all required services.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/04/2011 **Time of Death:** 03:46 PM

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

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: 02:56 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 10 Minutes
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age

Deceased Child's Household	Deceased Child	Alleged Victim	Female	5 Month(s)
Deceased Child's Household	Father	No Role	Male	43 Year(s)
Deceased Child's Household	Other Adult - BF's Girlfriend	No Role	Female	40 Year(s)
Deceased Child's Household	Other Adult - Adult Sibling (SS2); OC4's BM	No Role	Female	20 Year(s)
Deceased Child's Household	Other Child - OC4	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Male	52 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Female	51 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	70 Year(s)
Other Household 1	Other Adult - BM of OC2; SC's Cousin	Alleged Perpetrator	Female	25 Year(s)
Other Household 1	Other Adult - BM of OC3	Alleged Perpetrator	Female	25 Year(s)
Other Household 1	Other Adult - BF of OC3; SC's Cousin	Alleged Perpetrator	Male	29 Year(s)
Other Household 1	Other Adult - BF of OC2	Alleged Perpetrator	Male	28 Year(s)
Other Household 1	Other Child - OC1	Alleged Victim	Male	12 Year(s)
Other Household 1	Other Child - OC3	Alleged Victim	Female	3 Year(s)
Other Household 1	Other Child - OC2	Alleged Victim	Female	7 Year(s)
Other Household 2	Mother	No Role	Female	32 Year(s)
Other Household 3	Other Adult - BF of OC4	No Role	Male	21 Year(s)

LDSS Response

Within 24 hours of the SCR report dated 5/9/18, OCDSS attempted to contact the source, reviewed agency records, and assessed all children named in the report. OCDSS promptly assessed the safety of 2 children in BF's household as well, upon learning of them, and added them to the report. OCDSS contacted LE and learned they chose not to reinvestigate the death. LE informed and the ME confirmed the autopsy results had revealed the SC died of pneumonia and sepsis. OCDSS obtained LE records concerning their prior investigation, as well as an array of medical documents.

OCDSS re-interviewed those with information about the fatality, including family members who lived in the home at the time, LE, the ME, and agency staff. OCDSS was unable to interview the PGM due to advanced stages of her medical condition, and documented this accordingly. Information was also documented in receipt from the hospital at both the time of the SC's birth and the time of her death, as well as information from the SC's visiting nurse. The nurse had discussed safe sleep with the BF prior to the SC's death, and it was not noted the SC was sleeping in an unsafe environment. The 2011 Preventive case record noted similar observations/discussions. OCDSS discussed safe sleep and other child safety measures with all adults during this investigation.

In the 2011 Preventive Services record, documentation did not reflect the fatality was discussed with the family, services were offered, or medical records had been obtained. During the 2018 investigation, additional notes were located by the CPS CW who responded to the home with LE in 2011, which detailed OCDSS' response at the time. Information from those notes were then entered into the 2018 investigation case record.

The new information showed OCDSS responded to the home with LE on the date of the fatality. At that time in 2011, OCDSS observed several safety concerns for the condition of the home. The 13yo SS, BF, and PGM were interviewed. The BF stated SC had been left in the care of PGM that day while he worked, and he did not have any concerns. The SS was in another room of the home at the time of the fatality and provided a similar timeline of events as the PGM. The PGM said she placed the SC on her bed (noted as an adult-sized waterbed) while she briefly went outside, and when she came back minutes later, the SC was not breathing. The PGM then ran to a neighbor for help, who called 911 and assisted

with CPR. OCDSS observed where the SC was found, noting a bundle of blankets in the center of the PGM's waterbed (which had a foam pad on top) along with clothing on the bed. There were discrepancies in PGM's accounts to CPS and first responders as to where and how the child was placed and found. OCDSS questioned BF about the SC's usual sleep position/place. BF said SC either slept on her back or stomach, and either slept with BF in his bed, with PGM in her bed, or in a bassinet, propped and with blankets all around her to prevent her from rolling. PGM said the SC did not appear sick prior to the fatality.

A supervisory case conference was held on 4/5/11, and concerns were discussed. A reenactment with the ME showed the SC had been positioned on her right side on the top half of the bed when PGM found her, differing from notes and conclusions where it was recorded SC was found face down; however, OCDSS had documented there were discrepancies in PGM's account of events. Despite those discrepancies and various other CPS concerns for all the children in the home, it was not documented that a new report was made to the SCR in 2011.

The BF and his family reported they had not heard from BM in several years and she did not visit the 8yo sibling. OCDSS made notable efforts to locate and contact BM and were unsuccessful. The BF told OCDSS neither SC nor the 8yo sibling visited with their maternal half siblings. OCDSS spoke with the BF of those SS, who reported BM did not have contact with them.

The family continued to comply with services and work towards completing their goals. Supervised visitation and other services were provided. Casework and Family Court activity remained ongoing for those family members involved.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The fatality was reviewed by the Orange County Child Fatality Review Team in 2011. A second review for an updated discussion was scheduled for the July 2018 Child Fatality Review Team Meeting.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047254 - Other Child - OC1, Male, 12 Year(s)	047258 - Other Adult - BM of OC3, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047252 - Aunt/Uncle, Female, 51 Year(s)	Inadequate Guardianship	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047251 - Grandparent, Female, 70 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047255 - Other Adult - BM of OC2; SC's Cousin, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047251 - Grandparent, Female, 70 Year(s)	Inadequate Guardianship	Unsubstantiated

047254 - Other Child - OC1, Male, 12 Year(s)	047253 - Aunt/Uncle, Male, 52 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047256 - Other Adult - BF of OC2, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047259 - Other Adult - BF of OC3; SC's Cousin, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047253 - Aunt/Uncle, Male, 52 Year(s)	Inadequate Guardianship	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047258 - Other Adult - BM of OC3, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047255 - Other Adult - BM of OC2; SC's Cousin, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047256 - Other Adult - BF of OC2, Male, 28 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047259 - Other Adult - BF of OC3; SC's Cousin, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047254 - Other Child - OC1, Male, 12 Year(s)	047252 - Aunt/Uncle, Female, 51 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047256 - Other Adult - BF of OC2, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047251 - Grandparent, Female, 70 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047259 - Other Adult - BF of OC3; SC's Cousin, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047252 - Aunt/Uncle, Female, 51 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047253 - Aunt/Uncle, Male, 52 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047259 - Other Adult - BF of OC3; SC's Cousin, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047255 - Other Adult - BM of OC2; SC's Cousin, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047251 - Grandparent, Female, 70 Year(s)	Inadequate Guardianship	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047256 - Other Adult - BF of OC2, Male, 28 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047255 - Other Adult - BM of OC2; SC's Cousin, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047252 - Aunt/Uncle, Female, 51 Year(s)	Inadequate Guardianship	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047258 - Other Adult - BM of OC3, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047258 - Other Adult - BM of OC3, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047257 - Other Child - OC2, Female, 7 Year(s)	047253 - Aunt/Uncle, Male, 52 Year(s)	Inadequate Guardianship	Unsubstantiated

047260 - Other Child - OC3, Female, 3 Year(s)	047253 - Aunt/Uncle, Male, 52 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047251 - Grandparent, Female, 70 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047259 - Other Adult - BF of OC3; SC's Cousin, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047255 - Other Adult - BM of OC2; SC's Cousin, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047252 - Aunt/Uncle, Female, 51 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047258 - Other Adult - BM of OC3, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047251 - Grandparent, Female, 70 Year(s)	Inadequate Guardianship	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047255 - Other Adult - BM of OC2; SC's Cousin, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047253 - Aunt/Uncle, Male, 52 Year(s)	Inadequate Guardianship	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047256 - Other Adult - BF of OC2, Male, 28 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047259 - Other Adult - BF of OC3; SC's Cousin, Male, 29 Year(s)	Inadequate Guardianship	Substantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047252 - Aunt/Uncle, Female, 51 Year(s)	Inadequate Guardianship	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047256 - Other Adult - BF of OC2, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047258 - Other Adult - BM of OC3, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
047260 - Other Child - OC3, Female, 3 Year(s)	047258 - Other Adult - BM of OC3, Female, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
047430 - Deceased Child, Female, 5 Month(s)	047251 - Grandparent, Female, 70 Year(s)	Inadequate Guardianship	Unsubstantiated
047430 - Deceased Child, Female, 5 Month(s)	047251 - Grandparent, Female, 70 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

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

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

Additional information:

Though the source, BM, and PGM were not interviewed, OCDSS documented their diligent efforts to do so. BM could not be located, and PGM was unable to be interviewed due to advanced stages of her medical condition, although PGM was interviewed in 2011 and that information was pulled forward. All information and efforts were documented appropriately.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐

Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
A neglect petition was filed following a protective removal of OC3, against her parents, when concerns arose during this investigation (unrelated to the fatality). Appropriate services were offered/implemented, in addition to services already in place for other family members.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☒	☐	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
OC3 was removed during the investigation for reasons unrelated to the fatality. A safety plan was sufficient to protect the remaining children in the home, in lieu of removal for them.

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/31/2018	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	047259 Other Adult Male 29 Year(s)	
Comments:	OC3 was removed from her parents' care on 5/31/18 per court order stemming from concerns for parental drug use and violence in her presence. OC3 was placed in Foster Care and services were implemented. OC3 remained in Foster Care at the time of this writing, and Family Court hearings were ongoing.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/31/2018	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	047258 Other Adult Female 25 Year(s)	

Comments:	OC3 was removed from her parents' care on 5/31/18 per court order stemming from concerns for parental drug use and violence in her presence. OC3 was placed in Foster Care and services were implemented. OC3 remained in Foster Care at the time of this writing, and Family Court hearings were ongoing.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☒	☐	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☒	☐	☐	☐	☐
Alcohol/Substance abuse	☒	☐	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The following services noted were provided/referred after the fatality during the Preventive Services case in 2011. Also at that time, Early Intervention (EI) assessed SS1 (along with SC, prior to the fatality), and it was noted SS1 would be referred to another program within EI since he didn't meet eligibility criteria. Grief services were offered again in the 2018 investigation. Though Foster Care services were provided during this investigation, it was not selected as it was not an action taken as a result of the fatality.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
There were no current needs identified in relation to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the

fatality? No
Explain:
There were no current needs identified in relation to the fatality.

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?	Yes
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)
10/12/2010	Deceased Child, Female, 1 Days	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 1 Days	Father, Male, 36 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 1 Days	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report alleged BM gave birth to the SC on 10/11/10 and BM tested positive for cocaine and benzodiazepines. It was noted BM had other children who were not in her custody.

Report Determination: Indicated
Date of Determination: 03/16/2011

Basis for Determination:
OCDSS found BM gave birth to SC at 24-weeks' gestation. Both she and SC tested positive for cocaine. BM disclosed her cocaine use during pregnancy and did not receive prenatal care. BM left the family shortly after giving birth and did not report to OCDSS since discharge from the hospital. BF remained as the sole caregiver for the SC and the other 2 SS.

BF was added as a subject, but no evidence was recorded in the notes or investigation conclusion to back up that determination.

OCFS Review Results:
OCDSS appropriately filed a derivative neglect petition to include the SC on existing court orders, but OCDSS did not record evidence from the investigation as to why allegations were added and substantiated against BF for the SC. Documentation reflected he remained the SC's sole caretaker and adequately provided care for the SC and remained free from drug use (a former concern), and ensured any contact BM had with SC was supervised. There was no documentation of an interview with the older SS to assess for safety and risk. There was no evidence that safe sleep was discussed in detail, aside from discussing the dangers of co-sleeping. The 7-day safety assessment was inaccurate, and there was no review of CPS history.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Documentation did not reflect evidence upon which to add and substantiate the allegation of IG against BF regarding SC. Progress notes and the investigation conclusion did not detail reasons why the allegation was added or substantiated.
Legal Reference:
18 NYCRR 428.5
Action:
OCDSS will document pertinent decision-making points into the case record. The SVRO was consulted and revealed this area is still an ongoing struggle for OCDSS. Two previous PIPs were written for this issue in 2007 and 2013.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
There was no documentation of an interview with the older SS to assess for safety and risk.
Legal Reference:
18 NYCRR 432.1 (b)(3)(ii)(a)
Action:
The SVRO noted they are aware of this issue, as there is there is a current PIP for this citation which began in 2017.

Issue:
Review of CPS History
Summary:
There was no documentation that a review of CPS history was completed.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within one business day, OCDSS will review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded reports where the current report involves a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report. The history check should be documented in progress notes accordingly. The SVRO noted this was revealed as an issue in 2016 and successfully addressed by 2017, at which point the PIP was closed. This issue was identified again later in 2017. There is currently an existing PIP regarding this citation which OCDSS is currently working on.

Issue:
Timely/Adequate Seven Day Assessment
Summary:

A Safety Decision #4 was recorded, and noted a removal was necessary. SC was noted as a child who was placed in Foster Care, though the corresponding comments noted OCDSS would only take custody once the medically fragile SC was released from the hospital. Once released, the SC was never taken into protective custody. This safety decision was prematurely selected.

Legal Reference:

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

Action:

The SVRO noted this was identified as an issue in 2016 and was addressed in a PIP by 2017. This is not a current issue for OCDSS.

Issue:

Failure to provide notice of report

Summary:

There was no documentation that BM was provided with the Notice of Existence letter.

Legal Reference:

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

Action:

Though this has not previously been identified as an issue for OCDSS, this was identified as an issue which was repeatedly found in this family's history; specifically, in 8 CPS cases within the 3 years prior to this report being issued.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/06/2010	Sibling, Female, 12 Years	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes
	Sibling, Male, 10 Months	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 12 Years	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 10 Months	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	

Report Summary:

An SCR report alleged on 5/5/10, BF was arrested for possession of marijuana, a controlled substance, drug paraphernalia, and a weapon. The arrest occurred in the BF's home as a result of an investigation by a local drug task force. BF sold drugs from his home where the 2 SS, ages 12yo and 10-months-old, resided. At the time of the arrest, BF was the sole custodian of the children. The 12yo SS's mother had an unknown role.

Report Determination: Indicated | **Date of Determination:** 07/27/2010

Basis for Determination:

OCDSS found the alleged events to be accurate based on evidence gathered during the investigation. At the time of the police raid and for an extended period of time prior, BF was selling drugs out of the home in the presence of the 2 SS. BF also admitted to using drugs himself. He was incarcerated for a period of time prior to posting bail and awaiting sentencing, at which time the SS were cared for by relatives. A neglect petition was filed and the case was opened for services.

OCFS Review Results:

OCDSS appropriately devised safety plans with the family throughout the investigation as concerns arose, and filed a neglect petition and opened the case for services when warranted. The BM was not notified of the report or spoken with about the concerns, despite their serious nature. No secondary caretaker was identified in the RAP despite other caretakers being identified. The 24-hour assessment of safety was not adequate for the younger SS. Several notes were non-contemporaneous. OCDSS did not follow up with the younger SS's pediatrician when concerns for his weight were suspected, nor was this addressed timely with his parents. Early Intervention services were eventually offered for SS.

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

Issue:
Failure to provide notice of report
Summary:
The BM was not notified of the report or spoken with about the concerns, despite the serious nature of the concerns.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
Though this has not previously been identified as an issue for OCDSS, this was identified as an issue which was repeatedly found in this family's history; specifically, in 8 CPS cases within the 3 years prior to this report being issued.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
No secondary caretaker was identified despite the older SS's mother periodically caring for her as well as other caretakers who were caring for the children during the investigation.
Legal Reference:
18 NYCRR 432.2(d)
Action:
OCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile. The SVRO noted they are aware of this issue, as there is there is a current PIP for this citation which began in 2017.

Issue:
Timely/Adequate 24 Hour Assessment
Summary:
OCDSS did not assess the safety of the younger SS within 24 hours of the report. BF was incarcerated at the time of the report and though OCDSS sought locating information for the older SS and documented an assessment of her safety, the same was not done for the younger, more vulnerable SS.
Legal Reference:
SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:
The SVRO noted this citation was successfully addressed between December 2016 and October 2017, at which point the PIP was closed. This does not appear to be a current issue with OCDSS.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
14 progress notes were entered more than one month after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
OCDSS will document pertinent decision-making points into the case record. The SVRO was consulted and revealed this area is still an ongoing struggle for OCDSS. Two previous PIPs were written for this issue in 2007 and 2013.

Issue:
Failure to Offer Services
Summary:
The eldest SS's mother identified presently being in domestic violence relationships on more than one occasion throughout the investigation but DV services were never offered to her.
Legal Reference:

SSL 424(10); NYCRR 428.6

Action:

When service needs are identified, OCDSS will discuss the needs with the family and make appropriate referrals when necessary. The SVRO revealed there was a PIP created for this issue in 2017, which OCDSS is currently working on.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

Though 2 workers noted concerns that the 10-month-old SS looked underweight for his age, and despite BF signing a release to speak to the pediatrician, the pediatrician was never contacted.

Legal Reference:

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

Action:

OCDSS will make diligent efforts to contact relevant collateral contacts to potentially gather outside information pertaining to safety and risk of the child(ren). The SVRO noted they are aware of this issue, as there is there is a current PIP for this citation which began in 2017.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/01/2009	Sibling, Male, 0 Days	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 0 Days	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:

An SCR report alleged BM gave birth to the SS, and BM had a positive toxicology for crack cocaine. The BM admitted to using cocaine the evening prior to giving birth. The newborn SS's toxicology was pending at the time of the report. The BF's role was unknown.

Report Determination: Indicated | **Date of Determination:** 12/17/2009

Basis for Determination:

The investigation revealed both BM and the SS tested positive for drugs upon SS's birth. BM admitted to using crack during pregnancy and the day before she gave birth. Though she initially seemed interested, BM did not participate in treatment then left the home about 1 month into the investigation; her whereabouts remained unknown. BF filed for custody and there were no concerns for his ability to care for the SS.

OCFS Review Results:

OCDSS devised a safety plan with the family within 24 hours of the report such that SS was not to be left unsupervised with BM, given her disclosure of continued drug use. OCDSS encouraged BM to participate in an in-patient drug treatment program and provided her with information for services. OCDSS contacted the SS's pediatrician for information about the SS's health progression, and learned BF was meeting the SS's needs. OCDSS made multiple home visits and frequently discussed concerns and strengths throughout the investigation. Practice issues were found with regard to the adequacy of the RAP, notification letters, CPS history check, and timeliness of progress notes.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The BM was not listed as a caretaker despite her caretaking role for the SS during the investigation. The Elevated Risk Element regarding a child being born with positive toxicology was answered incorrectly, greatly affecting the overall score.

Legal Reference:

18 NYCRR 432.2(d)

Action:

OCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile. The SVRO noted they are aware of this issue, as there is there is a current PIP for this citation which began in 2017.

Issue:

Failure to provide notice of report

Summary:

There was no documentation that BF was sent a Notice of Existence letter, and BM's notification letter was not sent within the required 7-day timeframe. Her letter was generated the same day as the Notice of Indication letters.

Legal Reference:

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

Action:

Though this has not previously been identified as an issue for OCDSS, this was identified as an issue which was repeatedly found in this family's history; specifically, in 8 CPS cases within the 3 years prior to this report being issued.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Two progress notes were entered one month after the event dates, and the rest of the notes were entered at least 3 months after the event dates.

Legal Reference:

18 NYCRR 428.5

Action:

OCDSS will document pertinent decision-making points into the case record. The SVRO was consulted and revealed this area is still an ongoing struggle for OCDSS. Two previous PIPs were written for this issue in 2007 and 2013.

Issue:

Review of CPS History

Summary:

There was no documentation that CPS history was reviewed.

Legal Reference:

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

Action:

Within one business day, OCDSS will review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded reports where the current report involves a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report. The history check should be documented in progress notes accordingly. The SVRO noted this was revealed as an issue in 2016 and successfully addressed by 2017, at which point the PIP was closed. This issue was identified again later in 2017. There is currently an existing PIP regarding this citation which OCDSS is currently working on.

[redacted]

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

There is some history more than 3 years prior to the fatality, and substantial history which occurred between the time of the fatality and the current report concerning the children named in the current investigation.

3/23/06-7/11/06: BM and the BF of SS3 & SS4 IND for IG and PD/AM regarding the 2 CHN.

2/19/15-7/30/15: FAR case regarding SS1; allegations of IG, LMC, & IF/C/S against PGM & PA (custodians).

2/25/16-5/2/16: PU UNF for IG regarding SS1.

3/20/16 & subsequent report 3/21/16-6/20/16: OC3's BM IND for IG regarding OC3. PGM UNF for IF/C/S & IG regarding OC1, OC2, & OC3. OC2's BM UNF for IF/C/S, IG, LS, & PD/AM regarding the CHN.

12/13/16-4/11/17: PA and an unrelated household member IND for IG regarding SS1, OC1, OC2, OC3, & OC1's sibling.

3/16/17-4/21/17: OC3's BM UNF for PD/AM regarding OC3.

7/21/17 & subsequent report 7/25/17-9/28/17: PA, PU, OC2's BM, & OC3's BF IND for IF/C/S & IG regarding OC1, OC2, & OC3. OC3's BM UNF for same allegations. PD/AM against all 5 subjects was Unsub, as well as CD/A against PGM & OC2's BM regarding OC1 & OC2. Opened for Preventive Services.

9/26/17-11/28/17: PA, PU, & OC3's BF IND for IF/C/S regarding OC1 & OC3, and OC3's BF IND for IG & PD/AM regarding the 2 CHN. IG was Unsub against PA & PU for the CHN.

9/28/17 & subsequent report 11/6/17-12/7/17: UNF for XCP, LM, & IG against OC2's BM regarding OC2.

2/5/18-4/25/18: PA & OC2's BM UNF for EdN regarding OC2.

Known CPS History Outside of NYS

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

Preventive Services History

7/10/06-8/29/06 Services involved the 2 half-siblings following an IND case against BM and their BF for multiple concerns outlined during that investigation. Housing assistance was referred, & Early Intervention was provided. SS's BF became sole caregiver when BM "abandoned" CHN. SS's BF took a DV offender program. Case closed when the SS & their BF moved out of state; he agreed to a Preventive referral in that state.

7/27/10-1/5/12 Services involved SS1&2 following an IND case and neglect petition; concerns for BF's drug use, criminal activity in the home & BM's drug abuse, occurring while pregnant with SC. SS1&2 were placed in the custody of relatives and later returned to BF's custody. BF attended drug/alcohol Tx & was successful. BM's whereabouts were unknown after SC's birth. Services ended when court orders expired. Voluntary services were offered to BF but declined.

8/18/17-present. Services involved OC1, 2, & 3, OC3's parents, OC2's BM, PA, PU, & PGM; concerns for unsafe/unsanitary home & parental MH. OCDSS assisted with applications, monitored services, and the Preventive agency provided counseling/guidance for maintaining a clean, safe home. OCDSS addressed arising concerns for the CHN in that home. Other services were added upon removal of OC3.

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	Adjourned in Contemplation of Dismissal (ACD)
Respondent:	047246 Father Male 43 Year(s)	
Comments:	During a CPS investigation, between the dates of 5/6/10 and 7/27/10 (exact date not specified) a neglect petition was filed against the BF regarding SS1 and SS2. The BF was their sole caregiver at the time. The concerns regarded drug sales and criminal activity in the home. The mother of SS2, along with BF, consented to SS2 being placed under 1017 custody with the PGM. BF consented to SS1 being placed with the PA under the same article. This plan was made in preparation for BF's incarceration. On 11/16/10, the BF agreed to an Adjournment in Contemplation of Dismissal with an admission of neglect. The children were returned to his care at that time. It was court-ordered that the family be supervised by OCDSS for 12 months, in addition to participating in array of services. A Preventive Services case was opened, and closed when BF completed services successfully. It was later noted a derivative neglect petition was filed to include the SC on exiting court orders, once the SC was born.	

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