Child Fatality Report

Report Identification Number: AL-17-007

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

Issue Date: Jun 12, 2017

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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Warren
Gender: Female
Date of Death: 02/07/2017
Initial Date OCFS Notified: 02/08/2017

Presenting Information

On 2/8/2017 an SCR report was received by Warren County Department of Social Services (WCDSS) that alleged SC (1) died from injuries sustained during a motor vehicle accident which occurred on 1/5/2017. On the evening of 1/4/2017, SM was under the influence of drugs and alcohol as she ingested 6-12 beers and one Xanax (2 mg). SM could not recall what time she went to bed the night before the accident. On the morning of 1/5/2017 between 10:00 AM and 11:00 AM, SM picked the SC up from the MGM's home. On the way home, SM fell asleep as she swerved hitting another vehicle head on. As a result, SC was unconscious; she had blood in her mouth and nose, bruising on her torso and forehead, swelling to the forehead and bilateral fractures on both arms. SC was airlifted from Saratoga to Albany Medical Center where she died on 2/7/2017. SC had no known preexisting medical concerns. MGGM and MGGF have unknown roles.

Executive Summary

On 2/8/2017 WCDSS received an SCR report with allegations of DOA/Fatality, FX, II, IG, L/B/W, PD/AM and S/D/S against the SM regarding the SC. There was an open SCR report at the time, which was received on 2/5/2017, with allegations that on 2/5/2017 the SM was driving while ability impaired on substances, the SC was not properly restrained in the vehicle, the SM got into a head on collision and the SC was air lifted to the hospital.

The SM and SC resided with the MGGM and MGGF and there were no surviving siblings or other children residing in the home. Through interviews conducted by WCDSS, Saratoga County DSS and LE it was learned that the SM dropped the SC off on 2/4/2017 at the MGM's house for the night and the SM spent the night at a friend's house. The SM drank alcohol and used non-prescribed substances at the friend's home. The SM picked up the SC at the MGM's home around 10:00 AM on 2/5/2017 and was driving home when she fell asleep, crossed the center line and struck an oncoming vehicle head on. The SC was not properly restrained in the back seat and was ejected from her car seat, striking the inside of the vehicle and landing back into her car seat. The SC suffered multiple injuries and lost consciousness at the scene of the accident. The SC was air lifted to the hospital and placed on life support. The SM and SF withdrew life support on 2/7/2017 and the SC passed away at 3:45 PM.

An autopsy was performed and the cause of death was determined to be "cervical spinal cord injury due to atlanto occipital dislocation due to blunt force trauma". LE determined that the SM was under the influence of drugs at the time of the accident. The SM was arrested and charged with Vehicular Manslaughter 1st, Vehicular Assault 2nd, Driving While Ability Impaired by the Use of a Drug, as well as Reckless Driving, Failure to Properly Restrain a Passenger and Failure to Keep Right.

Through a review of CPS history, it was learned that the SM and BF had a history of drug use and had been referred for substance abuse treatment on multiple occasions. The BF lived with his parents and did not have regular visitation with the SC. Family members assisted in the care of the SC since her birth and had filed for custody in Family Court, but were unsuccessful.

WCDSS gathered the necessary documentation to support substantiating all of the allegations against the SM. WCDSS consulted with legal and at the time of this writing, were considering filing a neglect petition against the SM.

WCDSS opened a Family Services Intake to continue to monitor criminal charges against the SM and to monitor any Family Court intervention taken by WCDSS.

OCFS review of CPS history resulted in citations for adequacy of documentation of safety assessments and decision to close case to protective services. WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) the Regional Office has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Was the decision to close the case appropriate? Yes

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:
WCDSS appropriately Indicated and closed the case.

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: 02/07/2017 **Time of Death:** 03:45 PM

Date of fatal incident, if different than date of death: 02/05/2017
Time of fatal incident, if different than time of death: 10:22 AM

County where fatality incident occurred: SARATOGA

Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☒ Drug Impaired
- ☐ Absent
- ☒ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	64 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	69 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Other Household 1	Father	No Role	Male	27 Year(s)

LDSS Response

On 2/8/2017 WCDSS received an SCR report regarding the death of the 1-year-old female SC. The report was subsequent to an SCR report dated 2/5/2017. Through review of the interviews conducted with the SM, BF, family members, LE and hospital staff on 2/6/2017, WCDSS determined that the SC was hospitalized with serious injuries from a car accident that occurred on 2/5/2017. The SM fell asleep while driving with the SC not properly restrained in the backseat of the vehicle and crossed the center line, hitting an oncoming vehicle head on. The SC succumb to her injuries on 2/7/2017 when medical intervention was withdrawn. There were no surviving siblings or other children residing in the home. WCDSS coordinated their investigation with LE and conducted an MDT meeting at their local Child Advocacy Center.

The SM and BF were interviewed at the hospital upon receipt of the initial investigation. The BF admitted to being under the influence of drugs and alcohol during his interview at the hospital and shared that he used substances to cope with his

daughter's injuries. He reported that the SM kept the SC away from him and his family, therefore he had not seen the SC in nearly a year. He was aware the SM used drugs and knew that the SM's family members had cared for the SC as a result. The BF stated he had not tried to gain custody of the SC. Upon receipt of the fatality investigation, WCDSS spoke to the BF and PGM on the phone and attempted to schedule a HV, but the SF refused. WCDSS conducted a home visit and met with the SM and later met with her again at the county jail. WCDSS provided information on bereavement counseling services to the SM, SF, MGM, MGGM and MGGF as well as substance abuse treatment providers to the BF.

WCDSS conducted a thorough investigation. They spoke with LE, the District Attorney's office, Coroner's office, first responders, substance abuse treatment providers, the SC's pediatrician, hospital staff, and family members. An autopsy was performed and the cause of death was determined to be "cervical spinal cord injury due to atlanto occipital dislocation due to blunt force trauma". WCDSS determined there was credible evidence to substantiate all allegations against the SM and the case was closed as there were no surviving children. WCDSS consulted with legal and at the time of this writing were considering filing a neglect petition against the SM regarding the SC. WCDSS opened a Family Services Intake to monitor any Family Court intervention and to continue to monitor the criminal charges against the SM.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Coroner

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?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
036921 - Deceased Child, Female, 1 Yrs	036922 - Mother, Female, 20 Year(s)	Internal Injuries	Substantiated
036921 - Deceased Child, Female, 1 Yrs	036922 - Mother, Female, 20 Year(s)	Lacerations / Bruises / Welts	Substantiated
036921 - Deceased Child, Female, 1 Yrs	036922 - Mother, Female, 20 Year(s)	DOA / Fatality	Substantiated
036921 - Deceased Child, Female, 1 Yrs	036922 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
036921 - Deceased Child, Female, 1 Yrs	036922 - Mother, Female, 20 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
036921 - Deceased Child, Female, 1 Yrs	036922 - Mother, Female, 20 Year(s)	Swelling / Dislocations / Sprains	Substantiated
036921 - Deceased Child, Female, 1	036922 - Mother, Female, 20	Fractures	Substantiated

Yrs	Year(s)		

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:

WCDSS attempted to locate and interview the friend that SM was with the night before the incident and who's home she slept at. The SM only provided the person's name, but not the full address or phone number, so they were unable to be located.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Vehicular manslaughter **Degree:** 1			
Date	**Against Whom?**	**Date of Disposition:**	**Disposition:**

Charges Filed:			
03/22/2017	SM	Pending	Pending
Comments:	SM was charged with Vehicular Manslaughter 1st, Vehicular Assault 2nd, DWAI-drugs, as well as Reckless Driving, Failure to Properly Restrain a Passenger and Failure to Keep Right. SM remained in jail and her charges were pending.		

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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:
Bereavement services were offered to the SM, BF, MGM, MGGM and MGGF. The SM and BF were referred to substance abuse services. It was not documented if these services were utilized.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:

WCDSS provided the SM, SF, MGM, MGGM and MGGF with information on bereavement counseling. The SM and BF were provided with information on substance abuse services.

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? N/A
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/05/2017	15471 - Deceased Child, Female, 1 Years	15472 - Mother, Female, 20 Years	Inadequate Guardianship	Indicated	No
	15471 - Deceased Child, Female, 1 Years	15472 - Mother, Female, 20 Years	Fractures	Indicated	
	15471 - Deceased Child, Female, 1 Years	15472 - Mother, Female, 20 Years	Lacerations / Bruises / Welts	Indicated	
	15471 - Deceased Child, Female, 1 Years	15472 - Mother, Female, 20 Years	Swelling / Dislocations / Sprains	Indicated	
	15471 - Deceased Child, Female, 1 Years	15472 - Mother, Female, 20 Years	Internal Injuries	Indicated	
	15471 - Deceased Child, Female, 1 Years	15472 - Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:
The SCR report alleged on 2/5/2017 the SM was driving while impaired on substances with the SC in the vehicle. The SC was not properly restrained in the car seat as there was slack in between the SC as well as the car seat to the vehicle and SM got into a head on collision. As a result, the SC sustained multiple injuries; was unconscious, kept losing her pulse, had blood in her nose and mouth, bruising and abrasions to her torso and forehead, swelling to the forehead and bilateral humeral fractures. The SC did not regain consciousness and was air lifted to a hospital.

Determination: Indicated | **Date of Determination:** 04/24/2017

Basis for Determination:
WCDSS substantiated the allegations of FX, II, IG, L/B/W, PD/AM, and S/D/S against the SM regarding the SC. The SM admitted to using non-prescribed medication and drinking alcohol the night of 2/4/2017. The SM reported she was still very tired when she went to pick up the SC from the MGM's home the next morning and said that she probably

shouldn't have been driving. The SM reported she fell asleep at the wheel and went into oncoming traffic, causing the accident. The SM did not strap the SC into the car seat properly which caused the serious injuries to the SC. The SC died on 2/7/2017 when the SM and BF decided to withdraw care. The SM was later criminally charged for the incident.

OCFS Review Results:
WCDSS appropriately substantiated the allegations and closed the case as there were no surviving children. WCDSS made numerous collateral contacts and gathered sufficient documentation to support the determination. The SM, SF and family members were thoroughly interviewed. WCDSS made the appropriate referrals for grief counseling for the SM, BF, MGM, MGGM and MGGF and for substance abuse treatment for the SM and BF. WCDSS discussed the case with legal and opened a Family Services Intake to monitor any Family Court action taken by WCDSS against the SM and to monitor the criminal charges against the SM.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/07/2016	15521 - Deceased Child, Female, 8 Months	15526 - Grandparent, Male, 68 Years	Inadequate Guardianship	Indicated	Yes
	15521 - Deceased Child, Female, 8 Months	15524 - Mother, Female, 19 Years	Inadequate Guardianship	Indicated	
	15521 - Deceased Child, Female, 8 Months	15524 - Mother, Female, 19 Years	Lack of Supervision	Indicated	
	15521 - Deceased Child, Female, 8 Months	15525 - Grandparent, Female, 63 Years	Inadequate Guardianship	Indicated	
	15521 - Deceased Child, Female, 8 Months	15524 - Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:
The SCR report alleged on 4/7/2016 SM overdosed on heroin and became unconscious while responsible for the SC, eight months old. This was the second time the SM had overdosed on heroin in two weeks. The SM left the drugs accessible to the SC. The MGGM and MGGF were aware of the SM's heroin use and did not take precautionary measures to keep the SC safe.

Determination: Indicated | **Date of Determination:** 06/10/2016

Basis for Determination:
WCDSS Sub the allegation of IG against the SM regarding the SC. After SM's overdose she didn't return to the home to care for the SC or make an appropriate plan for the care of the SC. WCDSS Unsub the allegations of LS and PD/AM against the SM and IG against the MGGM and MGGF regarding the SC. The SM overdosed in the bathroom, the SC was asleep in the bedroom and the drugs weren't accessible to the SC. The MGGM and MGGF were aware of the SM's drug history and were in the home supervising the SM with the SC. They weren't aware the SM had obtained heroin and didn't allow the SM to have drugs in the home. SF was interviewed, was aware of SM's drug use and was also using drugs.

OCFS Review Results:
A safety plan was initiated with the SM's aunt that she would care for the SC and supervise the SM and BF with the SC. Both safety assessments inaccurately listed safety decision 2, when 3 should have been chosen. The case closed with the SM's aunt caring for the SC and saying she planned to apply for custody a second time in Family Court, although her custody petition had just been dismissed. The case closed with a safety plan in place and no one monitoring it. Preventive Services should have been offered to the SM and her aunt and WCDSS should have consulted with legal about taking Family Court action as the SM was not following treatment recommendations and she retained custody of the SC.

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

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

WCDSS inaccurately reflected the safety decision on the two approved safety assessments. The safety decision should have been 3 as a safety plan was implemented due to the SC being in immediate or impending danger of serious harm.

Legal Reference:

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

Action:

WCDSS will accurately complete safety assessments, documenting any safety plans or controlling interventions in place.

Issue:

Decision to close case to protective services

Summary:

Social services districts must conduct a review of the needs and circumstances of the family prior to case closing and may only close a case if all children are safe despite the withdrawal of controlling interventions, services have been offered and refused and there is not sufficient evidence to compel court action or if court intervention has been initiated and the petition was dismissed.

Legal Reference:

18 NYCRR Section 432.2(c); CPS Manual IV I.1

Action:

WCDSS will conduct a review of the needs and circumstances of the family prior to case closing and will only close a case if all children are safe despite the withdrawal of controlling interventions, services have been offered and refused and there is not sufficient evidence to compel court action or if court intervention has been initiated and the petition was dismissed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/21/2015	15501 - Deceased Child, Female, 4 Months	15502 - Mother, Female, 19 Years	Inadequate Guardianship	Indicated	Yes
	15501 - Deceased Child, Female, 4 Months	15502 - Mother, Female, 19 Years	Abandonment	Indicated	

Report Summary:

The SCR report alleged on 12/13/2015 the SM abandoned the SC with an unknown person. The SM no longer wanted to care for the SC and left the SC there. The SM had not returned for the SC and had been abusing heroin.

Determination: Indicated | **Date of Determination:** 01/15/2016

Basis for Determination:

WCDSS substantiated the allegations of IG and Abandonment against the SM regarding the SC. The SM left the MGGM and MGGF's home to stay with friends and use heroin. She failed to make a plan for the SC's care. The BF was interviewed and was also using drugs. SM was found by police and refused to go back home or contact the family members caring for the SC. The report was closed when the SM admitted herself into inpatient substance abuse treatment and agreed to have her aunt temporarily care for the SC. The SM's aunt applied for custody of the SC and her petition was pending in Family Court. The SM's aunt was providing supervision of the SM and BF with the SC.

OCFS Review Results:

WCDSS appropriately indicated the report for the SM abandoning the SC and failing to make a plan for her care. WCDSS contacted the necessary collaterals to support their determination and made the appropriate referrals for substance abuse treatment for the SM and BF. The safety assessments inaccurately reflected safety decision 2, when 3 should have been chosen as a safety plan needed to be implemented. WCDSS closed the case with the safety plan in place and no one monitoring it. Preventive Services should have been offered to the SM and her aunt. The SM's aunt

could have used assistance with the Family Court process of obtaining custody of the SC.

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
WCDSS inaccurately reflected the safety decision on the two approved safety assessments. The safety decision should have been 3 as a safety plan was implemented due to the SC being in immediate or impending danger of serious harm.

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

Action:
WCDSS will accurately complete safety assessments, documenting any safety plans or controlling interventions in place.

Issue:
Decision to close case to protective services

Summary:
Social services districts must conduct a review of the needs and circumstances of the family prior to case closing and may only close a case if all children are safe despite the withdrawal of controlling interventions, services have been offered and refused and there is not sufficient evidence to compel court action or if court intervention has been initiated and the petition was dismissed.

Legal Reference:
18 NYCRR Section 432.2(c); CPS Manual IV I.1

Action:
WCDSS will conduct a review of the needs and circumstances of the family prior to case closing and will only close a case if all children are safe despite the withdrawal of controlling interventions, services have been offered and refused and there is not sufficient evidence to compel court action or if court intervention has been initiated and the petition was dismissed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/12/2015	15512 - Deceased Child, Female, 10 Days	15511 - Mother, Female, 19 Years	Inadequate Guardianship	Unfounded	No
	15512 - Deceased Child, Female, 10 Days	15511 - Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:
The SCR report alleged on 8/2/2015 the SM gave birth to the SC and the SC tested positive for marijuana. The SM used marijuana during her pregnancy.

Determination: Unfounded | **Date of Determination:** 08/21/2015

Basis for Determination:
WCDSS unsubstantiated the allegations of IG and PD/AM against the SM regarding the SC. Although the SM and SC tested positive for marijuana at birth, the SM reported that she was only an occasional marijuana user and she stopped when she found out she was pregnant. The pediatrician records were reviewed and there was no negative effect documented for the SC due to the SM's marijuana use. The SM had a lot of family support and was residing with the MGGM and MGGF who were assisting in the care of the baby.

OCFS Review Results:
WCDSS accurately unsubstantiated the allegations against the SM regarding the SC, as there was no evidence that the SM’s marijuana use had an impact on the SC. WCDSS contacted hospital staff, the SC's pediatrician and multiple

relatives, including the BF, to gather information about the SM and the care of the SC. The report was closed as there were no concerns for the SC.
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

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

There is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No