Child Fatality Report

Report Identification Number: SV-21-031

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

Issue Date: Feb 07, 2022

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 1 month(s)

Jurisdiction: Westchester
Gender: Male

Date of Death: 08/18/2021
Initial Date OCFS Notified: 08/18/2021

Presenting Information

An SCR report alleged on 8/18/21, the parents did not provide the 1-month-old child with a minimum degree of care by having the child sleep on their bed with them. Around 4:00 AM, the mother fed the child a bottle and then laid the child down to sleep in between the parents. The mother woke up around 8:20 AM and found a blanket covering the child's face, obstructing his ability to breathe. The mother pulled the blanket off the child and the child was unresponsive and not breathing. The child appeared gray in color. The mother gave the child rescue breaths. The father called 911 at 8:29 AM. First responders arrived to the home and the child was transported to the hospital. The child was not able to be revived and was pronounced deceased at 8:59 AM. The 4-year-old sibling and the sibling's father had unknown roles.

Executive Summary

This fatality report concerns the death of the 1-month-old male subject child that occurred on 8/18/21. A report was made to the SCR on the same day regarding concerns the parents were bedsharing with the child when the child was discovered unresponsive and not breathing. At the time of his death, the child resided with his mother and 4-year-old sibling. The child's father did not reside with the child; however, he was present at the time of the fatal incident. The sibling was assessed to be safe in the care of his mother and grandmother. At the time of the child's passing, the family was receiving preventive services as the mother had a history of using marijuana and not properly supervising the sibling and another child in her care. Additionally, the sibling received services through Early Intervention.

Westchester County Department of Social Services (WCDSS) investigated the death through a multi-disciplinary team approach. The mother and father had extensive CPS histories with WCDSS, including each parent having a child removed from their care and adopted. Law enforcement closed their investigation without criminal charges. An autopsy was performed, and the cause of death was "asphyxia (suffocation) of a 7-week-old infant due to unsafe sleep in adult bed with mother and father on pillow with blanket over his face". The manner of death was an accident.

Around 4:00 AM on the day of the child's death, the child was fed and placed on top of a pillow that was on top of the bed. The child was covered with a blanket and both parents slept on the bed as well. The mother awoke and found the child unresponsive and not breathing. The mother performed CPR and 911 was called. First responders arrived at the home, took over resuscitation efforts and the child was transported to the hospital where he was pronounced deceased.

WCDSS conducted home visits and assessed the safety of the sibling throughout the investigation. The case was initiated timely, home visits were conducted, and the subject child's parents were interviewed. Collateral contacts were made and included gathering information from the medical examiner, the grandmother and the pediatrician. The case record did not reflect WCDSS spoke with father of the sibling. The required reports and Safety Assessments were completed timely; however, the Safety Assessments were completed inaccurately. The progress notes were entered contemporaneously to their event dates.

The allegations of Inadequate Guardianship and DOA/Fatality against the parents regarding the child were substantiated. The investigation revealed the parents did not provide the child with a minimum degree of care as they placed him in an unsafe sleeping environment with aggravating factors as the adults co-slept with the child while the child was on top of a pillow and had a blanket covering him. The mother was engaged in counseling at the time the investigation was determined, and the Preventive Services Case remained open.

PIP Requirement
WCDSS will submit a PIP to the Westchester Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the WCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, WCDSS 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?** No

Determination:

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

Explain:
The decision to close the investigation was timely and appropriate and the Preventive Services Case remained open. The Safety Assessments were completed with regard to risk and contained contradictory information as the safety factor regarding parent drug misuse was chosen but noted marijuana use did not impact the parents' ability to care for the sibling.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework activity was not commensurate with case circumstances as the father of the sibling was not interviewed, and records regarding the death were not obtained from relevant first responders present on the day of the child's death. The Safety Assessments and Risk Assessment Profile were completed inaccurately and did not accurately reflect case circumstances.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect attempts to interview the sibling's father. The record did not reflect attempts to gather information from all individuals present on the day of the child's death including first responders and hospital staff.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	WCDSS will contact, or make diligent efforts to contact, the source of all SCR reports so as to verify adequacy of report and possibly glean additional information. WCDSS will make efforts to make contact with a child's parents or guardians and other collaterals who may have relevant information regarding safety and risk and document efforts that were unsuccessful.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The safety factor of drug misuse was selected, but it was noted that the drug misuse did not impact the SS. The safety factor regarding the parents' unwillingness/inability to care for the SS was chosen, yet the case notes did not reflect such.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/18/2021 **Time of Death:** 08:56 AM

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

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: 08:29 AM
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? 4 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	Male	1 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Other Household 1	Other Adult - Sibling's Father	No Role	Male	32 Year(s)
Other Household 2	Father	Alleged Perpetrator	Male	25 Year(s)

LDSS Response

On 8/18/21, WCDSS received the report from the SCR and immediately initiated the investigation by attempting to contact law enforcement and the source of the report. The district attorney and medical examiner's offices were made aware of the death, and a CPS history check was documented. The safety of the sibling was assessed within the first 24 hours of the investigation.

The parents were contacted but were unable to be interviewed by WCDSS immediately following the death as they needed time to grieve. The sibling was assessed to be safe in the care of the maternal grandmother following the death. The grandmother did not have information regarding the death. The sibling was not interviewed as he had limited speech.

On 8/24/21, the mother was interviewed. The mother put the child down to sleep between 3:00 AM – 4:00 AM. The child was placed on top of a pillow on the adult bed and had a plush blanket around his lower half. The mother took a shower and then got in bed and laid in between the father and the child. Around 8:00 AM, the mother woke up to find the child under the blanket and not moving. It was common for the child to pull the blanket over his head. The mother called 911 and began CPR while the father got the sibling ready to go to the hospital. The mother waited outside for first responders and flagged down a police officer. First responders took over resuscitation efforts and transported the child to the hospital where he was pronounced deceased. The father did not have additional information regarding the death. Both parents stated they believed the child was in a safe sleeping environment as the bed was large enough for both adults and the child to sleep.

Collateral information was gathered from the medical examiner and pediatrician. The medical examiner deemed the death was a result of the unsafe sleep environment. The medical examiner's report stated EMS responded to the family's home to find the child without a heartbeat, performed CPR and transported the child to the hospital. The pediatrician had no concerns for the care of the children. Although law enforcement was involved in the investigation, the record did not reflect the responding officers were interviewed. Additionally, the record did not reflect information was gathered from first responders including the fire department, EMS or emergency department staff.

WCDSS appropriately offered the parents Victim Assistance Services referrals, mental health and bereavement counseling and continued to provide preventive services to mother and sibling. The parents were referred to CASAC as they had a history of marijuana misuse; however, they were not engaged in CASAC services as the time the investigation was determined.

Official Manner and Cause of Death

Official Manner: Accident

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

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes
Comments: The death was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059181 - Deceased Child, Male, 1 Month(s)	059183 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
059181 - Deceased Child, Male, 1 Month(s)	059183 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
059181 - Deceased Child, Male, 1 Month(s)	059326 - Father, Male, 25 Year(s)	DOA / Fatality	Substantiated
059181 - Deceased Child, Male, 1 Month(s)	059326 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Other	☐	☒	☐	☐
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:
The record did not reflect an attempt to contact the sibling's father. Conversations with all individuals present on the day of the death, including first responders and hospital staff, were not noted.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: The RAP noted the child did not die as a result of abuse or maltreatment; however, WCDSS substantiated the allegation of DOA/Fatality.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The surviving sibling did not need to be removed as a result of the fatality investigation.				

Legal Activity Related to the Fatality

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

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 parents were offered mental health counseling referrals in response to the death. The father declined the service and the mother was engaged in counseling prior to the death of the child. The parents were referred for drug screenings as they had a history of misusing marijuana. The sibling continued receiving Early Intervention services.

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? N/A
Explain:
Although there was a 4-year-old sibling, the record reflected the child had a speech delay and therefore, counseling would not be beneficial for him.

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 bereavement services in response to the death. The mother was previously engaged in counseling and continued treatment with her therapist.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

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

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/01/2020	Sibling, Male, 3 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 3 Years	Mother, Female, 29 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
An SCR report alleged the sibling had unknown developmental disabilities and was nonverbal. On 11/1/20, the mother became irate and hit the sibling on his back with excessive force for unknown reasons. The sibling cried as a result; however, it was unknown if he sustained injuries. The mother left the sibling alone for at least 5 minutes without an adequate plan for his care. Due to the sibling's age and developmental disabilities, the sibling should not have been unsupervised for any period. The sibling was not harmed as a result of being unsupervised.

Report Determination: Unfounded | **Date of Determination:** 12/28/2020

Basis for Determination:
The allegations of Inadequate Guardianship and Lack of Supervision were unsubstantiated. The record reflected there was no credible evidence to support the allegations and that the mother provided adequate care and supervision to the sibling. The investigation revealed the mother left the sibling unattended at a hospital while she had x-rays taken and the sibling was not permitted to be in the room. The case remained open for preventive services.

OCFS Review Results:
The investigation was initiated timely, and the source of the report was contacted. An SCR history check was documented untimely. Progress notes were entered contemporaneously to their event dates. Interviews with the mother were comprehensive. Written notice was provided to the mother, but not the sibling's father. The record did not reflect attempts to contact or interview the sibling's father. The 7-day Safety Assessment was completed timely and accurately.

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:
The record did not reflect attempts to contact the sibling's father regarding the SCR report.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
WCDSS will make casework contacts per 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.

Issue:
Failure to provide notice of report
Summary:
Although the mother was provided with written notice of the SCR report timely, the record did not reflect written notice was provided to the sibling's father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
WCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

Issue:
Review of CPS History
Summary:
Although an SCR history check was completed, it was completed untimely on 11/25/20.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/04/2019	Sibling, Male, 4 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 4 Years	Mother, Female, 28 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 4 Years	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report alleged on a daily basis, the mother used crack while she was the sole caretaker for the sibling. The mother was not able to adequately care for the sibling when she was high, and she behaved erratically. On at least one occasion, she drove while she was impaired on crack with the sibling in the vehicle. She sold crack out of the home in the presence of the sibling. There were random people in and out of the home. On at least one occasion, the mother was physically violent toward another adult in the presence of the sibling. The situation was ongoing.

Report Determination: Indicated | **Date of Determination:** 08/14/2019

Basis for Determination:
The investigation revealed that the mother's marijuana misuse placed the sibling at high-risk of being placed in Foster Care. The mother fought with neighbors and other adults in the community and risked the child being removed if she was to be arrested for her actions. Although WCDSS determined there was credible evidence to substantiate Inadequate Guardianship and reflected such in the Investigation Conclusion Narrative, the allegation was inadvertently unsubstantiated in Connections. Lack of Supervision was added to the case and unsubstantiated; however, the Investigation Conclusion Narrative did not explain the basis of determination.

OCFS Review Results:
The investigation was initiated timely, the mother was interviewed, and the home was assessed. A CPS history check was documented timely. Written notice of the SCR was provided to the mother, but not to the sibling's father. Interviews with collateral contacts gathered information relating to safety and risk. Progress notes were entered contemporaneously to their event dates. The case remained open for preventive services. The Investigation Conclusion Narrative was not consistent with how the allegations were determined in Connections.

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:
Although the mother declined to name the sibling's father, further efforts to identify and contact him were not documented.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
WCDSS will make casework contacts per 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.

Issue:

Failure to provide notice of report

Summary:

Although the mother was provided with written notice of the SCR report, the sibling's father was not documented to have been provided with written notice of the SCR report.

Legal Reference:

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

Action:

WCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/03/2019	Other Child - Cousin, Male, 5 Years	Father, Male, 23 Years	Inadequate Guardianship	Far-Closed	Yes
	Other Child - Cousin, Female, 9 Years	Father, Male, 23 Years	Inadequate Guardianship	Far-Closed	
	Other Child - Cousin, Male, 5 Years	Aunt/Uncle, Female, 27 Years	Inadequate Guardianship	Far-Closed	
	Other Child - Cousin, Female, 9 Years	Aunt/Uncle, Female, 27 Years	Inadequate Guardianship	Far-Closed	
	Other Child - Cousin, Male, 5 Years	Aunt/Uncle, Female, 27 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Other Child - Cousin, Female, 9 Years	Aunt/Uncle, Female, 27 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Other Child - Cousin, Male, 5 Years	Other Adult - Aunt's Partner, Male, 28 Years	Inadequate Guardianship	Far-Closed	
	Other Child - Cousin, Female, 9 Years	Other Adult - Aunt's Partner, Male, 28 Years	Inadequate Guardianship	Far-Closed	

Report Summary:

An SCR report alleged the paternal aunt, her partner and the father sold drugs out of the home in the presence of the then 5 and 9-year-old cousins. The aunt smoked marijuana and took unknown pills to the point of impairment while caring for the children. Further details were unknown.

OCFS Review Results:

The case was appropriately tracked FAR, and the family was engaged. The 7-day Safety Assessment was completed timely and accurately. The FLAG was completed with the family. Interviews contained relevant information. The record did not reflect the adults were provided with written notice of the SCR report. Progress notes were entered contemporaneously to their event dates.

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

Issue:

FAR-Failure to Provide Notice of Report

Summary:

Although the aunt was provided with a FAR brochure, the record did not reflect the adults or absent fathers were provided with written notice of the SCR report.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:
No later than seven days after receipt of a child protective report that has been assigned to the Family Assessment Response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/25/2019	Sibling, Male, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report alleged the mother resided with the sibling. The mother sold marijuana, crack and heroin out of the home. The drug distribution attracted multiple drug users to the home throughout the day, making an unsafe environment for the sibling.

Report Determination: Unfounded | **Date of Determination:** 03/25/2019

Basis for Determination:
The allegation of Inadequate Guardianship was unsubstantiated as the investigation did not reveal credible evidence that the mother was involved in illegal drug activities while she was the sole caregiver of the sibling. The mother was providing the sibling with minimal standards. The case remained open for preventive services.

OCFS Review Results:
The SCR report was initiated timely and home visits were made. The interviews with the mother were thorough and progress notes were entered timely. The CPS history check and 7-day Safety Assessment were completed timely. The Risk Assessment Profile reflected case and family circumstances. The record did not include attempts to contact the sibling's father for an interview or to provide written notice of the SCR report. Collateral contacts were made to gather relevant information.

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:
Although the record reflected locating information for the sibling's father, attempts to interview him were not documented.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
WCDSS will make casework contacts per 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.

Issue:
Failure to provide notice of report

Summary:
Although the mother was provided with written notice of the SCR report timely, the record did not reflect written notice was provided to the sibling's father.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:

WCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

[redacted]

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

03/30/18- 11/01/18 The mother was substantiated for PD/AM and IG and unsubstantiated for LS of the sibling. The maternal grandmother was unsubstantiated for IG and PD/AM of the sibling.

02/16/18- 04/16/18 The father was unsubstantiated for IG regarding his then partner's children.

02/01/18- 04/02/18 The mother was unsubstantiated for PD/AM and IG of the sibling.

09/15/15- 11/04/15 The father was substantiated for IG of another child.

03/20/15- 04/23/15 The father was substantiated for IG, XCP and B/S for his then partner's children.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 11/01/2018

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 11/01/2018

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine

Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
Counseling services were provided to the mother through a community-based resource. The sibling was provided with Early Intervention services.

Preventive Services History

01/21/14- 09/16/16- A services case was opened regarding the mother leaving another child home alone unsupervised. The other child had access to marijuana and was found wandering outside of the home in her underwear. The mother agreed to a conditional surrender and consented to a permanent neglect. The mother's parental rights regarding the other child were

terminated.

04/23/15- 06/07/19 Preventive services were opened for the father and his then partner after a Neglect Petition was filed regarding the then partner's child who was burned and was hit with a belt by the partner. Mental health services, parenting, casework counseling, childcare, and a DV referral was made. A child the father had custody of was added to the case; however, he was removed from the case when he was freed for adoption on 2/4/19.

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