# Child Fatality Report

## Report Identification Number: SV-17-017

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

## Issue Date: Nov 10, 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 | 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:** 7 month(s)
**Jurisdiction:** Westchester
**Gender:** Male
**Date of Death:** 05/29/2017
**Initial Date OCFS Notified:** 05/29/2017

### Presenting Information

On 5/29/17, SM was visiting a friend (OA), and while at OA's home, SM fed 7-month-old SC, and then laid him down to sleep in a playpen. SC had trouble falling asleep. At approximately 7PM, SM checked on SC and he was not breathing and unresponsive; SM waited 30 minutes before calling 911. SM then started CPR after calling emergency services. SC was in cardiac arrest for approximately 10 minutes during the time SM hesitated to call for help. SM failed to seek immediate life saving interventions that could have saved SC, and as a result, SC died.

### Executive Summary

This fatality report concerns the death of a 7-month-old male (SC) that occurred on 5/29/17. A report was made to the SCR on that same date with allegations of IG, LM, and DOA/Fatality against SM regarding SC. Westchester County Department of Social Services (WCDSS) conducted an investigation surrounding SC's death. Neither a Death Certificate nor final autopsy report were available for review at the time of this writing, but the ME reported findings of pathogens in SC's lungs and blood. A cause and manner of death had not yet been determined.

The fatality report was received as a subsequent report to a CPS investigation that was opened on 4/19/17 regarding concerns unrelated to the death of SC. SC was born healthy, with no pre-existing medical conditions; however, at 4 months old, SC was prescribed the use of a breathing treatment as needed due to congestion. SC was seen regularly by his pediatrician and noted to be a healthy child. SM had no other children, and SC's BF was unable to be identified/located.

On the date of the incident, it was discovered SM and SC were visiting a friend (OA) at her home. SC slept between SM and OA in OA's bed, but at approximately 5PM, OA laid SC down in a Pack and Play on his stomach, swaddled in a blanket, with a pacifier in his mouth. The Pack and Play also contained toys, a blanket and a pillow. Around 7:20PM, SM found SC unresponsive, still on his stomach and swaddled, with vomit coming from his mouth and on his clothes. WCDSS discovered SM was educated surrounding safe sleep practices by professionals on more than one occasion, and it was regular practice for SM to place SC on his stomach to sleep. After concluding OA had caretaker responsibilities for SC on the date of his death, WCDSS added OA as a subject with allegations of IG against her regarding SC.

From the time the investigation began to the time of its closure, WCDSS met with the family, assessed the home environments of the SC and OA, and referred SM and OA to appropriate services. WCDSS did not find credible evidence to support the allegations in the report, and therefore unfounded and closed the investigation.

A review of the family's CPS history was conducted, and as a result, concerns were identified related to casework practices. On 5/22/17, WCDSS completed an investigation, but the Risk Assessment Profile was inaccurate. On 12/8/15, SM was living in New York City, and the Administration for Children's Services (ACS) completed an investigation. It was found that the 7 Day Safety Assessment was inaccurate, ACS failed to provide safe sleep education to SM, the case record contained information that was not factual, and efforts to locate a child's father were not adequate.

The aforementioned review of case history resulted in citations related to casework practices for both WCDSS and ACS, as the family had CPS history in both jurisdictions. In response, each will submit a Program Improvement Plan to their regional office to address what actions they will take or have been taken to address the cited issues. For citations where a PIP is currently implemented, WCDSS and ACS will review the plan(s) and revise as needed to further address on-going 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

**Explain:**
The decision to unfound and close was case was appropriate. The casework was commensurate with the case circumstances. All notes were entered timely, and safety assessments were adequate.

**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 gathered sufficient information to determine 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:** 05/29/2017 **Time of Death:** 08:31 PM

**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:** Unknown
**Did EMS 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

**How long before incident was the child last seen by caretaker?** 2 Hours

**Is the caretaker listed in the Household Composition?** No

**At time of incident supervisor was:**

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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 | 7 Month(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 25 Year(s) |
| Other Household 1 | Other Adult - SM's Friend | Alleged Perpetrator | Female | 25 Year(s) |

## LDSS Response

On 5/29/17, WCDSS received an SCR report regarding the death of SC. WCDSS initiated their investigation within 24 hours, and coordinated their efforts with LE and other members of their MDT. WCDSS and LE met with SM and OA at the local police department to begin gathering information and a timeline of events. At that time, OA was not a subject on the report. WCDSS discovered SC was an only child, and they resided at a mother and child shelter. SM reported she only knew SC's BF's first name, as SC was a result of a one night stand and was not involved in SC's life. The fatal incident occurred while SM and SC were visiting OA at OA's home. Further, WCDSS found OA had a 2-year-old male child of her own; however, this child was at his grandmother's house on the date of the incident. A CPS history check was conducted, and WCDSS completed visits to the case address as well as OA's home where SC died.

Through interviews, SM reported SC had been congested, and was given a nebulizer treatment the morning of his passing; he was otherwise healthy and had a recent check-up in the weeks prior. WCDSS determined on 5/29/17, SM and SC went to OA's home at approximately 12PM. Upon arriving, SM reported SC appeared tired, so she placed him on his back in OA's full size bed. SM reported SC awoke around 3PM, and she prepared and fed SC a bottle. SM explained after the feeding, she laid down in the bed with OA, and placed SC in-between them; all fell asleep. It was found OA awoke to SC fussing at around 5PM, so she swaddled him in a blanket and placed him in a separate room, in her son's playpen, on his stomach, with a pacifier in his mouth. OA then went back to bed with SM, and the two slept until around 7PM. SM reported she went to awaken SC around 7:20PM, and found him still swaddled in a blanket, but the pacifier was not in his mouth; SC had vomit on his mouth and clothing. SM brought SC into OA's room, and began to unwrap him. This is when

SM and OA noticed SC was pale and his breathing was very faint. OA began CPR and called 911, as SM was hysterical. EMS arrived several minutes later, and transported SC to the hospital, where he was pronounced deceased at 8:31PM. WCDSS offered both SM and OA bereavement/grief services.

WCDSS spoke with shelter staff and discovered SM had been educated numerous times regarding safe sleep practices. The shelter in which SM and SC resided was observed by WCDSS, and it was found SM had appropriate sleeping provisions for SC, which SM reported were being used regularly. WCDSS made efforts to try and identify/locate SC's BF to no avail.

Through supervisory consults, WCDSS made the decision to add OA as a subject, due to OA providing a caretaking role to SC on the date of his death. WCDSS provided OA with the appropriate notification letter, conducted a CPS history check, completed a thorough face to face interview which corroborated SM's timeline of events, and observed/assessed the safety of OA's child noting no concerns. WCDSS additionally offered appropriate services to OA.

WCDSS spoke with an array of collateral contacts, including the ME and SC's pediatrician. At the time of this writing, neither a Death Certificate nor an autopsy were available. The ME did, however, confirm that bacterial microorganisms, as well as other pathogens, were found in SC's lung tissue and blood. The ME also noted SC had no marks/bruises or signs of constriction on his body. Despite these results, the cause of death had not yet been determined by the ME. WCDSS could not establish a causal connection between SC's death and any maltreatment factor, therefore they ultimately unfounded and closed the investigation.

## Official Manner and Cause of Death

**Official Manner:** Pending
**Primary Cause of Death:** Undetermined if injury or 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
**Comments:** This fatality investigation was conducted by the Westchester County Multidisciplinary Team.

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?** Yes
**Comments:** This fatality was reviewed by the Westchester Child Fatality Review Team.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 041562 - Deceased Child, Male, 7 Mons | 041564 - Other Adult - SM's Friend , Female, 25 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 041562 - Deceased Child, Male, 7 Mons | 041563 - Mother, Female, 25 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 041562 - Deceased Child, Male, 7 Mons | 041563 - Mother, Female, 25 Year(s) | DOA / Fatality | Unsubstantiated |
| 041562 - Deceased Child, Male, 7 Mons | 041563 - Mother, Female, 25 Year(s) | Lack of Medical Care | 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:**
WCDSS contacted all appropriate collaterals regarding SC's death. WCDSS also appropriately assessed the safety of OA's child and found no concerns.

## 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?** 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 | Needed but 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:**
WCDSS offered SM and OA bereavement counseling in response to SC's death. Additional appropriate services were offered to SM and OA. The record does not reflect if funeral assistance was offered.

**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:**
There were no SS.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
Grief services were offered to SM, which she accepted. Substance abuse and preventive services were offered to OA, which she ultimately declined.

## 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?** 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) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 05/22/2017 | Other Child - OA's Child, Male, 2 Years | Other Adult - OA's Child's BF, Male, 28 Years | Lacerations / Bruises / Welts | Indicated | Yes |
| | Other Child - OA's Child, Male, 2 Years | Other Adult - OA's Child's BF, Male, 28 Years | Inadequate Guardianship | Indicated | |

**Report Summary:**
This report was received by WCDSS with concerns OA and her child's BF engaged in a physical altercation in front of her child. Further, it was alleged the child's BF struck the child in the head, leaving a bruise.

**Determination:** Indicated **Date of Determination:** 07/10/2017

**Basis for Determination:**
WCDSS completed the investigation by conducting interviews, home visits, and speaking to collateral contacts. Appropriate services were offered. WCDSS substantiated the allegation of IG against OA's child's BF.

**OCFS Review Results:**
The investigation met all statutory requirements; however, the RAP was completed inaccurately: "Yes" should have been selected for question 7 regarding OA's domestic violence history.

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

**Issue:**
Adequacy of Risk Assessment Profile (RAP)
**Summary:**
For Question 7 in the RAP, "Yes" should have been selected in regard to OA's domestic violence history.
**Legal Reference:**
18 NYCRR 432.2(d)
**Action:**
WCDSS will complete all RAPs accurately.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 04/19/2017 | Deceased Child, Female, 6 Months | Mother, Female, 25 Years | Inadequate Food / Clothing / Shelter | Unfounded | No |
| | Deceased Child, Female, 6 Months | Mother, Female, 25 Years | Inadequate Guardianship | Unfounded | |

| | | | | |
|---|---|---|---|---|
| | Deceased Child, Female, 6 Months | Mother, Female, 25 Years | Lack of Medical Care | Unfounded |

**Report Summary:**
This report was received by WCDSS with concerns SM would leave SC locked in their room at the family shelter where they resided, to go to another floor for various amounts of time. Further concerns noted were that SM was not taking SC to the doctor, despite SC being ill for several weeks, and SM would take SC out into the cold weather inappropriately dressed. Lastly, the report alleged SM would "manhandle" SC by slamming him onto a rubber floor mat, and SM would then yell at SC and force him to "handle his own bottle".

**Determination:** Unfounded | **Date of Determination:** 06/14/2017

**Basis for Determination:**
WCDSS completed a thorough investigation and addressed all allegations via interviews, home visits, and collateral contacts. WCDSS found no evidence to support SM was not providing a minimum degree of care to SC, and appropriately unfounded the allegations.

**OCFS Review Results:**
The investigation met all statutory requirements.

**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) |
|---|---|---|---|---|---|
| 12/08/2015 | Other Child - OA's child, Male, 10 Months | Other Adult - SM's Friend, Female, 24 Years | Inadequate Guardianship | Unfounded | Yes |
| | Other Child - OA's child, Male, 10 Months | Other Adult - SM's Friend, Female, 24 Years | Parents Drug / Alcohol Misuse | Unfounded | |
| | Other Child - OA's child, Male, 10 Months | Other Adult - OA's child's BF, Male, 26 Years | Inadequate Guardianship | Unfounded | |
| | Other Child - OA's child, Male, 10 Months | Other Adult - OA's child's BF, Male, 26 Years | Parents Drug / Alcohol Misuse | Unfounded | |

**Report Summary:**
This report was received by ACS with concerns OA engaged in numerous physical altercations with her child's father, in the presence of the child. There were further concerns OA and the father were using cocaine and marijuana on a regular basis while the sole caretakers of their child.

**Determination:** Unfounded | **Date of Determination:** 01/13/2016

**Basis for Determination:**
ACS and WCDSS (assigned a secondary role due to BF residing in Westchester County) completed the investigation by conducting interviews, home visits, and speaking to collateral contacts. Appropriate services were offered. ACS unsubstantiated the allegations noting they did not have evidence to show OA or the child's BF's actions had any negative, lasting effects on the child.

**OCFS Review Results:**
OCFS reviewed the investigation and found the 7 Day Safety Assessment completed by ACS was inadequate, as decision #3 was chosen, but no Safety Factors were selected. There was no discussion with OA surrounding safe sleep. It is documented in a progress note that OA had no previous CPS history, which is not factual. Efforts to locate and interview the child's BF were not adequate; ACS could have asked the BF's probation officer for a working phone number for the BF, or directed WCDSS to attempt to meet with him at an upcoming probation appointment.

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

**Issue:**
Timely/Adequate Seven Day Assessment

**Summary:**
ACS selected safety decision 3 for the 7 Day Safety Assessment; however, selected no corresponding safety factors.
**Legal Reference:**
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
**Action:**
ACS will complete Safety Assessments accurately.

**Issue:**
Failure to provide safe sleep education/information
**Summary:**
ACS failed to have a discussion with OA surrounding safe sleep at any point in the investigation.
**Legal Reference:**
13-OCFS-ADM-02
**Action:**
ACS will provide safe sleep education to parents of children 12 months old and younger, and document that appropriate sleep provisions were observed.

**Issue:**
Case record contains information that relevant, useful, factual and objective
**Summary:**
It was documented in a progress note that OA had no previous CPS history, which is not factual, as OA did have history.
**Legal Reference:**
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
**Action:**
ACS will not document information that is not factual in the case record.

**Issue:**
Face-to-Face Interview (Subject/Family)
**Summary:**
Efforts to locate and interview the child's BF were not adequate. ACS, who had the primary role, could have asked the BF's probation officer for a working phone number for the BF, or directed WCDSS, who was assigned secondary, to attempt to meet with BF at an upcoming probation appointment.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(a)
**Action:**
ACS will make diligent efforts to conduct a face to face interview with all subjects listed on a report.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 01/28/2015 | Other Child - OA's child, Male, 1 Days | Other Adult - SM's Friend, Female, 23 Years | Parents Drug / Alcohol Misuse | Unfounded | No |

**Report Summary:**
This report was received with concerns OA gave birth to her son and both she and the newborn tested positive for marijuana.

**Determination:** Unfounded | **Date of Determination:** 03/26/2015

**Basis for Determination:**
WCDSS completed a thorough investigation that included interviews, home visits, and collateral contacts. WCDSS

| |
|---|
| discovered the newborn's positive toxicology did not have any negative effects on his health or well-being. WCDSS offered OA appropriate services. WCDSS did not have evidence to support the allegations in the report and appropriately unsubstantiated. |
| **OCFS Review Results:**<br>The investigation met all statutory requirements. |
| **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.

## 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?** | ☐ | ☐ | ☒ | ☐ |

## 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