Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-18-034

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

Issue Date: Oct 09, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 05/31/2018
Initial Date OCFS Notified: 05/31/2018

Presenting Information

An SCR report alleged the 1-month-old SC had an untreated bacterial infection, causing a rash to cover her body. On 5/31/18, while in the care of her mother, the SC stopped breathing. The mother called for EMS, who responded to the home and took the SC for medical treatment. The SC was pronounced dead at 5:23PM as a result of the untreated bacterial infection. The roles of the 3-year-old SS, SF, MGM, and father of the 3-year-old were unknown.

A subsequent report of the fatality was made on 6/1/18. The subsequent report stated the SM and SF were home with the SC on 5/31/18, and the SM put the SC to sleep on a twin mattress. Approximately 1.5 hours later, the SM found the SC unresponsive and called 911. Police arrived and brought the SC out of the home where EMS worked on the child. The SC was brought to the hospital and pronounced dead. The SC was seen with skin discoloration. It was unknown if the child had any medical conditions that contributed to her death.

Executive Summary

On 5/31/18, Westchester County Department of Social Services (WCDSS) responded to an SCR report concerning the death of the 6-week-old SC. WCDSS immediately spoke with LE, who separately responded to the hospital and interviewed family and staff. WCDSS learned the SC was found unresponsive in the MGM's home, in the sole care of the SM. LE relayed that hospital staff noted SC had sores about her body from an untreated infection and was malnourished.

At the time of the fatality, WCDSS was involved with the family in an open CPS investigation, initiated the day after the SC was born. A safety plan was made upon her discharge from the hospital whereby the MGM was to supervise all contact between the SC and her parents. This stemmed from concerns that the SC was born with positive toxicology for marijuana, and both parents tested positive as well. It was noted that MGM had custody of SM's other child, the 3yo SS, since the time of his birth due to protective concerns for the SM's ability to care for him.

WCDSS was in the MGM's home on the date of the fatality, before the SC died. WCDSS observed the SC and SS, and no concerns for their conditions were noted, though the SC was fully clothed and swaddled. It was on that date that WCDSS learned the family had not been abiding by the safety plan. WCDSS and MGM arranged for MGM's friend to assist with supervision in her absence, as she planned to go out later that day. WCDSS cleared the friend and spoke with her about the terms of the safety plan. Later that day when the SM discovered the SC unresponsive, reportedly in her crib with nothing obstructing her breathing, the friend was not in the home and again the SM was unsupervised with both CHN.

Upon follow-up with the Dr. identified as the SC's pediatrician, it was learned the SC had never been seen medically prior to her death. Hospital staff provided medical documentation regarding the severity of the SC's skin condition and malnourishment.

Due to the safety concerns for the SS given the circumstances of the fatality as well as MGM's failure to abide by the safety plan, the SS was removed and placed into FC. The SS also had a rash and infection in need of immediate medical attention, which was treated medically upon entry into FC. MGM remained active with visiting the SS and was awaiting the implementation of services, as she was the only caregiver listed on the CPS-Services/Foster Care case which was opened. WCDSS inquired of the SS's BF, though he could not be identified.

Grief support services were offered to the family. WCDSS learned the SF had a young child of his own who resided with

his mother, though despite efforts, WCDSS was not able to contact the child or his mother. Though she no longer had children in her care, the SM may have benefitted from community-based referrals for services to address known concerns for the SM.

WCDSS appropriately substantiated all allegations against the SM and SF, including DOA/Fatality. After considerable contact with the family and collaterals, WCDSS noted some credible evidence to believe the SC died of medical reasons, with the contributory cause being lack of appropriate medical care. MGM was IND regarding her inability to protect the SC and SS. WCDSS filed petitions in Family Court against all 3 caregivers; hearings remained ongoing. It was noted the criminal investigation concerning the fatality was also ongoing.

PIP Requirement

For issues identified in historical cases, WCDSS will submit a PIP to the Spring Valley Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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?** 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:

All safety assessments were detailed, accurate, and completed in a timely manner.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
The decision to close the investigation was appropriate, as were the determinations of all allegations. After the investigation closed, the Foster Care/CPS-Services case was opened and remained open at the time of this writing.

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: 05/31/2018 **Time of Death:** 05:23 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: 05:02 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 90 Minutes
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	61 Year(s)
Other Household 1	Sibling	Alleged Victim	Male	3 Year(s)
Other Household 2	Other Adult - SS's BF	No Role	Male	18 Year(s)

LDSS Response

Immediately upon receiving the SCR report, WCDSS spoke with LE and learned an array of essential information regarding facts LE had already gathered about the fatality. WCDSS then conducted their own interviews, and continued to gather information from collateral contacts. WCDSS documented relevant information from the CPS case that was open at the time of the fatality, particularly regarding the safety plan in place for the SC.

WCDSS spoke with the MGM and learned she was not supervising the SM with the SC at the time of the fatality, which had been a stipulation of the safety plan. WCDSS had reiterated this safety plan at a home visit earlier that day, and modified the plan to include another adult to assist with supervision in MGM's absence. This was in response to learning the family was not abiding by the safety plan. WCDSS had not noticed the SC to be malnourished or with medical issues at the time of that contact, as the SC was fully clothed and swaddled. WCDSS spoke to the other adult about the plan; however, after the CW left the home, so did MGM, SF, and eventually, the other adult. SM told WCDSS the SC napped in her crib and SS napped in a bed, while SM slept as well. SM did not specify how long the SC was asleep, but she said she herself was asleep 90 minutes before checking on the SC and noticing she was having shallow breathing. It was established she called the MGM and SF between 4:30 and 5PM, and SF called 911 at 5:02PM. SF arrived at the home just prior to EMS. EMS attempted to revive the SC, but were unsuccessful. The SC arrived at the hospital in full cardiac arrest and was soon after pronounced deceased.

Hospital records described the SC's skin appearance as having "serious drainage from lesions around the neck, skin rash, genital multiple scarred patches over the body, total component erosions of the diaper rash with marginal scaling, and multiple satellite lesions." She was also noted as having a distended abdomen, and weighed only 5lbs. As records did not indicate the immediate cause of death, WCDSS requested information of the ME about the autopsy results but were unsuccessful. WCDSS contacted the pediatrician and confirmed the SC had never been seen. The SS was up to date medically.

The SF told LE he, SM, and MGM noticed a rash on the SC 1 week prior to her death and they discussed taking SC to the Dr., though SM refused, citing financial and insurance limitations. SF told WCDSS he did not take SC to the Dr. for fear that DSS would remove her. MGM denied ever seeing the SC unclothed, as she said the SM cared for the SC at all times. The SM and MGM confirmed SM resided in MGM's home for 3 weeks, then SM and SC returned to the home SM shared with the SF for the 2 weeks leading up to the SC's death. When questioned about the SC's condition, SM said the SC's rash worsened over a 2-week period and she planned to take SC to the Dr. the following week. SM reported having no concerns for SC's weight. The SC was her birth weight at the time of her death.

Significant concerns were immediately revealed for the safety of the 3yo SS as evidenced by the MGM's lack of protective capacity. The MGM had custody of the SS because of concerns for the SM, and was supposed to be the supervisor in a safety plan for the SC. Despite this, the MGM regularly allowed the parents to care for both CHN unsupervised. On 5/31/18, WCDSS arranged for a medical evaluation of the SS and learned he had a diaper rash which the Dr. noted was "extensive;" otherwise, he was found to be in good health and the symptoms cleared with medications. Based on the seriousness of the safety concern for the SS, WCDSS conducted a removal of the SS and the SS entered FC, pursuant to Family Court Act 1021.

WCDSS inquired of the SF as to whether he had any other CHN. It was learned he had a 3yo son with another woman, but he refused to share any information about him. WCDSS was unable to locate the child by using database searches at their disposal.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046786 - Deceased Child, Female, 1 Mons	046787 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
046786 - Deceased Child, Female, 1 Mons	046787 - Mother, Female, 36 Year(s)	DOA / Fatality	Substantiated
046786 - Deceased Child, Female, 1 Mons	047363 - Father, Male, 38 Year(s)	Lack of Medical Care	Substantiated
046786 - Deceased Child, Female, 1 Mons	047363 - Father, Male, 38 Year(s)	Inadequate Guardianship	Substantiated
046786 - Deceased Child, Female, 1 Mons	047359 - Grandparent, Female, 61 Year(s)	Lack of Medical Care	Substantiated
046786 - Deceased Child, Female, 1 Mons	046787 - Mother, Female, 36 Year(s)	Lack of Medical Care	Substantiated
046786 - Deceased Child, Female, 1 Mons	047363 - Father, Male, 38 Year(s)	DOA / Fatality	Substantiated
046786 - Deceased Child, Female, 1 Mons	047359 - Grandparent, Female, 61 Year(s)	Inadequate Guardianship	Substantiated
047360 - Sibling, Male, 3 Year(s)	047359 - Grandparent, Female, 61 Year(s)	Lack of Medical Care	Unsubstantiated
047360 - Sibling, Male, 3 Year(s)	047359 - Grandparent, Female, 61 Year(s)	Lack of Supervision	Substantiated
047360 - Sibling, Male, 3 Year(s)	047359 - Grandparent, Female, 61 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?	☒	☐	☐	☐
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?	☒	☐	☐	☐

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:
Fatality-related services were offered. WCDSS documented concerns for SM, but she was not provided information for services in the community upon conclusion of her involvement with WCDSS. The SM was not added to the CPS-Services case, although the SS had not been in her custody at the time he was placed into Foster Care and the plan was for him to return to the MGM once safe.

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
The SS was removed as a result of concerns for him as well as concerns regarding the circumstances of the SC's death.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?
☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/06/2018	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	047359 Grandparent Female 61 Year(s)	
Comments:	On 6/1/18, the SS was removed from the MGM upon consent, pursuant to Family Court Act 1021. Court was held on 6/6/18, which alleged that the SS was abused, severely abused, and neglected by MGM, the SM, and the SF. This was a result of concerns related to the fatality. The court document noted, "The deceased child was suffering from an untreated bacterial infection, was emaciated, underweight, and had ulcers about her body and diaper area;" the SS was also diagnosed with an infection that required immediate medical care. It was noted a safety plan had been in place regarding the SC, placing her in the care of the MGM, but MGM allowed both the SM and SF, who had histories of substance abuse, to have unsupervised contact with both of the children. It was ordered that the SS was to remain in Foster Care, and the court process was ongoing.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/06/2018	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	046787 Mother Female 36 Year(s)	

Comments:	The same petition and allegations were filed against the MGM, SM, and SF regarding the SS (see above).

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/06/2018	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	047363 Father Male 38 Year(s)	
Comments:	The same petition and allegations were filed against the MGM, SM, and SF regarding the SS (see above).	

Have any Orders of Protection been issued? No

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:
WCDSS made a referral to the Victim's Advocacy to refer for fatality-related services to the family. Services were provided to MGM in an open CPS-Services/Foster Care case after the fatality. Referrals to community-based services

such as MH and substance abuse treatment may have been beneficial to be made to the SM as a result of concerns documented.

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? Yes
Explain:
Concerns for the SS's safety following the fatality prompted the necessity to initiate Foster Care Services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Some services were provided to the MGM, SS's caregiver. Services were not provided to the SM or SF. All caregivers were referred for grief counseling 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? 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)
04/17/2018	Deceased Child, Female, 1 Days	Father, Male, 38 Years	Lack of Medical Care	Substantiated	Yes
	Deceased Child, Female, 1 Days	Mother, Female, 36 Years	Lack of Medical Care	Substantiated	

Deceased Child, Female, 1 Days	Grandparent, Female, 61 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 1 Days	Father, Male, 38 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 1 Days	Mother, Female, 36 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 1 Days	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged the SM gave birth to the SC on 4/16/18, and the SC had a positive toxicology for marijuana. The role of the SF was unknown. It was noted the SM had a 3yo child (SS) who was not in her care. It was also noted the SM had no prenatal care. The SM admitted she smoked tobacco laced with the drug "K2" with the SF, but the report did not specify when.

Report Determination: Indicated | **Date of Determination:** 06/15/2018

Basis for Determination:
Allegations were Sub against SM and SF, and IG was added and Sub against MGM. SM and SF did not seek routine medical care for SC, or when she presented with medical issues. A safety plan was made due to concerns for the parents' marijuana use and SM's history of MH; SC was cared for by MGM with no unsupervised contact with the parents. SC died on 5/31/18 and a separate investigation ensued; just prior, WCDSS learned MGM had been allowing SM to care for SC despite the safety plan. SS was in Article 6 custody of MGM. WCDSS took further action regarding the SS, as noted in the activity of the fatality investigation. PD/AM was Unsub as the SC did not exhibit withdrawal symptoms.

OCFS Review Results:
WCDSS appropriately involved CASAC to drug test the parents and provide services. WCDSS took appropriate actions when necessary, and repeatedly clarified and assessed the terms of the safety plan. WCDSS immediately addressed concern with all adults when learning they were not abiding by the plan, and assisted in making other arrangements. Though WCDSS observed SC on more than one occasion during the investigation, including the date of death (prior to the fatality), SC was often covered by clothes and/or swaddled. WCDSS did not contact the pediatrician (an essential collateral contact given the allegations), safe sleep was never discussed, and a referral for MH was never made.

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

Issue:
Failure to provide safe sleep education/information

Summary:
Though WCDSS was in the home upon the SC's discharge from the hospital, and on more than one occasion following that visit, safe sleep was never discussed with any of the caretakers.

Legal Reference:
13-OCFS-ADM-02

Action:
WCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
SM reported SC had a pediatrician, though WCDSS did not make an attempt to contact this Dr. whom SM identified. Given the significant vulnerability of SC's age and the circumstances of the case (testing positive for drugs at birth) this would have been an essential collateral contact when determining the allegation of LMC, as alleged in the report.

Legal Reference:

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

Action:

WCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Issue:

Failure to offer services

Summary:

The SM's apparent MH status and history of MH was noted as a safety and risk concern throughout the investigation, though a referral for community-based MH services were not documented as being offered.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

When service needs are identified, WCDSS will make the appropriate service referral(s) in an effort to determine whether there are services that can benefit the family. The Spring Valley Regional Office was consulted and revealed there is presently an existing PIP regarding this issue, which WCDSS is currently working on improving.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/22/2016	Sibling, Male, 1 Years	Grandparent, Female, 59 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:

An SCR report alleged MGM had custody of SS. On 4/12/2016, MGM physically assaulted a 94-year-old unrelated household member by punching him in the face, and threatened to kill him in the presence of the SS. SM had an unknown role.

Report Determination: Unfounded **Date of Determination:** 06/06/2016

Basis for Determination:

WCDSS interviewed all parties (with the exception of the SS, who was not of a developmental age to be interviewed) and no disclosures were made to prove accuracy of the allegations. WCDSS determined MGM and SS resided with the unrelated household member whom she cared for. WCDSS provided information for MGM to obtain her own housing when it was learned she was to possibly be evicted. No additional safety factors were identified, though it was noted MGM obtained Article 6 custody of SS due to SM's MH and cognitive abilities.

OCFS Review Results:

WCDSS completed a thorough investigation into the reported concerns and assessed for safety throughout the duration of their involvement.

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

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

The family had one CPS case more than 3 years prior to the fatality. On 7/30/2014, the date of the SS's birth, SM was the alleged subject of IG and IF/C/S regarding the SS. SS went into 1017 placement with the MGM in light of the concerns for SM, and the case was indicated against SM on 9/10/2014.

Known CPS History Outside of NYS

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

Preventive Services History

A Preventive Services case was opened on 8/6/2014 following the birth of SS and concerns that SM was unable and/or unwilling to care for him. The concerns were that SM was not bonding with or attentive to the newborn SS, SM did not have stable housing, and had apparent MH issues. SM agreed to a safety plan that SS be cared for by MGM while Family Court was ongoing. On 8/19/2014, SM agreed to 1017 placement with MGM to care for SS. Services provided included: a MH evaluation and any recommended treatment, parenting skills, and Preventive case management. The Preventive Services case was closed on 4/12/2016 when the MGM was awarded Article 6 custody of the SS. It was noted the MGM consistently ensured the SS's safety, and that the SS's needs were met. It was further noted the MGM and SS were linked with a community-based service at the time the case was closed, for additional support.

Legal History Within Three Years Prior to the Fatality

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

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
01/20/2016	There was not a fact finding	CustodyGuardianship assigned to relative or non-relative (Article 6 non-foster care)
Respondent:	None	
Comments:	After the SS had been in the MGM's care and custody for over 2 years, first under Family Court Act 1017 and then under Family Court Act 1055, the MGM filed for and then obtained Article 6 custody of the SS on 8/10/16. This custody hearing was held in conjunction with the fact-finding hearing for the SM whereby she was adjudicated to have neglected the SS. The dispositional terms noted WCDSS was relieved of any orders of supervision upon custody being granted to the MGM, and visitation could occur under terms and conditions as agreed upon between the SM and the MGM.	

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