Child Fatality Report

Report Identification Number: SV-23-027

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

Issue Date: Nov 20, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 3 month(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 05/26/2023
Initial Date OCFS Notified: 05/26/2023

Presenting Information

An SCR report alleged on 05/26/23, the 3-month-old child was found unresponsive and not breathing at 9:24 AM. Prior to being found unresponsive, the mother fed the child and placed her on the bed around 8:30 AM. The mother left the child on the bed with the 19-year-old maternal aunt. At 9:24 AM, the aunt realized the child was not breathing and was unresponsive. EMS was contacted and the mother was instructed to administer CPR. First responders arrived and took over resuscitation efforts. The child was pronounced deceased at 10:03 AM. The child was otherwise healthy, and the mother and aunt did not have an explanation for the death. A subsequent report was received on the same day alleging the child was limp yet in rigor mortis at the time the family discovered she was unresponsive. The child had mucus and "froth" coming from her nose. The child was transported to the hospital where she was pronounced deceased at 9:53 AM. The MGM was listed as an alleged subject of the report.

Executive Summary

This report concerns the death of the 3-month-old SC that occurred on 05/26/23. Two SCR reports were received on the same day, alleging the SM laid the SC down to sleep and later found the SC unresponsive and limp. The SC subsequently died, and the family did not have a plausible explanation for her death. At the time of the death, the SC resided with the MGM, SM, 2, 4, and 9-yo SSs, 15yo MU, an adult MU and 2 adult MA. The surviving children were safe with their respective parents.

Westchester County Department of Social Services (WCDSS) contacted LE upon receipt of the SCR report. The outcome of the criminal investigation remained unknown. An autopsy was performed; however, at the time this report was written, the autopsy report had not yet been received. There were no findings of trauma or congenital disease.

The SM, MGM, 15yo MU and 19yo MA were interviewed regarding the fatal incident. It was reported that the SC was placed on her side on a bed with the 2 and 4yo SSs. The 19yo MA sat at the end of the bed with her back to the SC. The MU discovered the SC unresponsive, limp, and blue. The MA and MGM called 911 and CPR was administered until first responders arrived. Resuscitation efforts were continued while the SC was transported to the hospital where she was pronounced deceased. The adult MU, 18yo MA and 9yo SS were not home at the time of the fatal incident.

The investigation revealed there was garbage, dirt, insects, and vermin in the home. WCDSS made significant and immediate attempts to assist the family in finding alternate housing. The SM and the 2 and 4yo SSs began residing in a shelter. The 10yo SS went out of state to visit with her BF. The MGM’s home was cleaned and met minimal standards.

WCDSS obtained hospital and pediatrician records. There were no documented concerns. The fathers of the children were contacted. The BF of the 15yo MU did not have information regarding the death and there were no noted concerns for the safety of the children. The father of the 9yo SS did not have concerns. The BF of the SC and 2 and 4yo SSs lived out of state and did not have information regarding the death or safety of the children.

WCDSS added and substantiated the allegation of IF/C/S against the MGM and SM as the home was initially found in a deplorable condition. The allegation of IG was inappropriately unsubstantiated. The Investigation Conclusion Narrative stated there was not a fair preponderance of evidence to support the actions or inactions of the SM or MGM directly contributed to or caused the death. However, the record reflected that the SC co-slept with 3 SSs and her SM, creating an unsafe sleeping environment. A bassinet was observed in the home that appeared to be unfit for safe sleeping. The record

reflected the ME said the SC had a bacterial infection that had the ability to release toxins that negatively affect organs; however, there was no way to test if the toxins were released and caused the death. The ME reported the SM said the SC was healthy and did not show signs of illness. The ME was considering the unsafe sleeping environment as the cause of death. Additionally, on 07/10/23, the ME stated there was “no explanation for the death, therefore, it is being ruled unsafe sleep.” The record reflected that this information was considered, yet due to bacteria found in the SC's system, a fair preponderance of evidence was not reached to substantiate the allegations.

WCDSS offered the family an abundance of services in response to the fatality. They were enrolled in counseling. The MGM declined a services case; however, the SM accepted the referral, and the case was opened on 07/25/23. Parenting skills training and case management referrals would be provided to the family.

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?** 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?** No

Explain:
The record reflected the “ME stated he will rule unsafe sleep based on the information of the sleep environment”, “no other factors or evidence to explain” the SC’s death, and the death was "deemed preventable".

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:

The case remained open for services.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Although the investigation revealed that the SC regularly slept in a bed with the SSs and SM and the ME considered the unsafe sleeping environment to be a cause of death, WCDSS unsubstantiated the allegation of IG.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	WCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Westchester Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/26/2023 **Time of Death:** 10:00 AM (Approximate)

Time of fatal incident, if different than time of death: 08:30 AM

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: 09:25 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ 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	Aunt/Uncle	Alleged Victim	Male	15 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	20 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	18 Year(s)

Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	9 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Other Household 1	Other Adult - Father of 9-year-old Sibling	No Role	Male	26 Year(s)
Other Household 2	Father	No Role	Male	24 Year(s)
Other Household 3	Other Adult - Father of 15-year-old Uncle	No Role	Male	52 Year(s)

LDSS Response

On 05/25/23, WCDSS received the SCR report. Within the first 24 hours of the investigation, WCDSS coordinated investigative efforts with LE, completed a CPS history check, contacted the source, and notified the DA of the death. The surviving CHN were assessed to be safe.

A case conference note reflected that the DA and LE reported the home was deplorable and there was an insect infestation. The SM placed the SC on the bed to sleep and the 15yo MU found the SC to appear gray and he alerted the SM. The home was overcrowded.

On 05/26/23, a home visit was conducted and the MGM and 15yo MU were interviewed. The MGM stated she heard someone say call EMS and saw the SM holding the SC while the MU said the SC was not breathing. There was a white substance coming from the SC's nose, and the 19yo MA and MGM called 911. At the time of the fatal incident, the MGM, SM, 15yo MU, 19yo MA, and 2 and 4yo SSs were home. The MU said he checked on the CHN and saw the SC was on the bed. He picked her up and she was limp and blue and alerted the MA. The MGM and MU's recollections of the event were consistent.

On 05/26/23, the SM reported the SSs would be staying with relatives as she did not want to return to the MGM's home and said that she was struggling to find alternative housing. The SM called the 19yo MA, who declined to be interviewed face-to-face. The MA stated that the SC slept at the top of the bed and the MA laid down with the 2 and 4yo SSs at the foot of the bed. The SSs were awake and playing. Around 9:00AM, the 15yo MU entered the room and observed the SC's blue lips and gray skin. The MA did not provide further information.

The SM was interviewed again on 05/30/23. She received education on safe sleep recommendations by hospital staff at the time of the SC's birth and the pediatrician advised her to place the SC to sleep on side to aid in any possible acid reflux. The SC had a crib but previously co-slept. On the day of the death, between 4:00-5:00 AM, the SM fed the SC, burped her, and placed her to sleep in a bassinet. Around 7:00 AM, she fed the SC and laid her on her on the bed with the 2 and 4yo SSs. She asked the 19yo MA to watch the children while she left the room. Around 9:20 AM, the SM heard screaming and that something was wrong with the SC. The SC was laying face up on the bed with bubbles coming from her nose. She administered CPR until first responders arrived, took over, and transported the SC to the hospital.

On 06/25/23, WCDSS attempted a follow up visit with the MGM; however, she said the 15yo MU did not need to "relive this tragedy". On 06/25/23, the 9yo SS, who was out of state with her father, was assessed via video chat. On 06/29/23, a home visit was made to a relative's house and the 18yo and 19yo MAs and 20yo MU declined to be interviewed.

The 9yo SS was assessed to be safe at her father's home by an out of state CPS and no concerns were noted.

Hospital records noted that the SM fed the SC and placed her to sleep around 8:30 AM. The 19yo MA checked on the SC and noticed she looked ill. The SM administered CPR until first responders arrived. The SC was transported to the hospital, and she was pronounced deceased. Records were received from the pediatrician; however, it remained unknown if the SM was advised to position the SC on her side to sleep.

WCDSS appropriately offered and opened a preventive case for the family. The services case remained open at the time of this writing.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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
065048 - Deceased Child, Female, 3 Mons	065049 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
065048 - Deceased Child, Female, 3 Mons	065050 - Grandparent, Female, 58 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065048 - Deceased Child, Female, 3 Mons	065051 - Aunt/Uncle, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
065048 - Deceased Child, Female, 3 Mons	065049 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065048 - Deceased Child, Female, 3 Mons	065049 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
065048 - Deceased Child, Female, 3 Mons	065051 - Aunt/Uncle, Female, 19 Year(s)	Inadequate Guardianship	Unsubstantiated
065048 - Deceased Child, Female, 3 Mons	065050 - Grandparent, Female, 58 Year(s)	Inadequate Guardianship	Unsubstantiated
065048 - Deceased Child, Female, 3 Mons	065050 - Grandparent, Female, 58 Year(s)	DOA / Fatality	Unsubstantiated
065057 - Aunt/Uncle, Male, 15 Year(s)	065050 - Grandparent, Female, 58 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065058 - Sibling, Female, 9 Year(s)	065049 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065058 - Sibling, Female, 9 Year(s)	065050 - Grandparent, Female, 58 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

065059 - Sibling, Female, 4 Year(s)	065049 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
065059 - Sibling, Female, 4 Year(s)	065050 - Grandparent, Female, 58 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065059 - Sibling, Female, 4 Year(s)	065049 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065060 - Sibling, Female, 2 Year(s)	065049 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
065060 - Sibling, Female, 2 Year(s)	065049 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065060 - Sibling, Female, 2 Year(s)	065050 - Grandparent, Female, 58 Year(s)	Inadequate Food / Clothing / Shelter	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?	☒	☐	☐	☐

Additional information:

The 19yo MA declined to be interviewed face-to-face; however, was interviewed over the phone. The 20yo MU and 18yo MA declined to be interviewed. The father resided out of state and was interviewed over the phone.

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	☒	☐	☐	☐

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 as a result of information uncovered during 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	Offered, but	Offered, Unknown	Not Offered	Needed but	N/A	CDR Lead to

Child Fatality Report

	Death	Refused	if Used		Unavailable		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 appropriately offered the family referrals to victim's advocates, mental health treatment and bereavement counseling. Parenting classes were offered. WCDSS aided the mother and siblings in immediately moving from the home and into a shelter. WCDSS continued their efforts to provide the family with resources to obtain permanent housing.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ With none of the issues listed noted in case record

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)
03/23/2023	Aunt/Uncle, Male, 15 Years	Grandparent, Female, 58 Years	Educational Neglect	Unsubstantiated	Yes

Report Summary:
An SCR report alleged the 15-year-old MU was absent from school 48 days and was failing as a result. The MGM was aware of the situation and failed to intervene and correct it.

Report Determination: Unfounded

Date of Determination: 05/05/2023

Basis for Determination:
The allegation of EdN was unsubstantiated against the MGM. The Investigation Conclusion Narrative stated that the MU was suspended from school as a result of fighting and was put on probation. The MGM reported school bus transportation was inconsistent; however, the record did not reflect this information was explored further. The MU started attending school and his attendance improved and he attended an afterschool program for tutoring; however, he was required to attend summer school and repeat classes the following school year.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed timely. CPS history was reviewed. The MGM and MU were interviewed; however, the interviews were allegation focused. The MGM declined to allow WCDSS to interview household members, including 4 children; however, a legal consultation was not documented. WCDSS noted the demographics of the children remained unknown, yet they were named in the report. EdN was inappropriately determined as there was a fair preponderance of evidence that the MU's absences from school caused him to fail classes. There was a pre-determination of safety and risk. WCDSS was unable to fully access the home.

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

Issue:
Assessment as to need for Family Court Action

Summary:
Although the MGM refused to allow WCDSS to have contact with household members with the exception of the MU, WCDSS was aware other children resided in the house. The record did not reflect a legal consultation took place regarding the need for possible court intervention in order to assess the safety of the children.

Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:
WCDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court and shall initiate such action, whenever necessary.

Issue:
Appropriateness of allegation determination

Summary:
Although the MU's attendance improved after the CPS investigation was initiated, the MU failed classes, was required to

attend summer school and repeat classes as a result. The MU's unexcused absences had a negative impact on his education. The allegation of EdN was inappropriately unsubstantiated.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

WCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Westchester Regional Office if further guidance is needed.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

The MGM declined to provide identifying information regarding the father of her children; however, a review of CPS history named the father of the MGM's children, yet the demographic information available in Connections was not documented to have been explored.

Legal Reference:

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

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:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

Although the MGM denied WCDSS access to interview other home members, there was a pre-determination of safety and risk as the interviews with the MGM and MU were allegation focused. The record did not encompass how safety and risk were assessed for the children residing in the home.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

WCDSS will prioritize making an adequate assessment of safety and risk to all children in the household and continue an ongoing assessment of safety and risk throughout the length of the investigation.

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

From 04/27/07 to 04/08/20, there were 6 cases against the MGM, 2 of which were FAR cases. The allegations included IG, LMC, EdN, IF/C/S, FX, L/B/W and PD/AM regarding the MGM's now adult children and the 15-year-old MU. Three of the investigations were substantiated against the MGM. There were 2 investigations of another adult regarding IG and XCP of the MGM's children, which were unsubstantiated.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Preventive Services History

A services case was opened on 03/04/08 as a CPS investigation revealed the MGM's home was in an unsanitary condition with 8 children residing in it, including the now 15-year-old MU. There were concerns the children did not receive preventive and required medical attention. Neglect petitions were filed against the MGM and her then husband and there

was a finding of neglect. The family was provided with parenting services, case management, housekeeping services and family preservation services. After completing the court-ordered services, the case was closed on 10/05/10.

A services case was opened on 05/20/15 as the MGM did not ensure the now 15-year-old MU was enrolled in school. A neglect petition was filed against the MGM, which resulted in a finding of neglect and the family was ordered to a year of supervision. The family required assistance with referrals and engagement in mental health therapy and financial assistance. The family engaged in mental health therapy, and the uncle was enrolled in school. He received Individualized Education Plan services. The family met all court-ordered requirements and the order of supervision expired on 02/02/16. The family continued to work with WCDSS voluntarily until there were no safety concerns and the family no longer required services. The case was closed on 10/17/17.

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