Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-034

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

Issue Date: Dec 21, 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: 5 year(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 06/30/2023
Initial Date OCFS Notified: 06/30/2023

Presenting Information

Westchester County Department of Social Services (WCDSS) completed an OCFS-7065 Agency Reporting Form on 7/3/23 after learning of the 5-year-old subject child's death. There was an open services case at the time of death due to the subject child being in foster care.

Executive Summary

On 6/30/23, WCDSS was notified that the 5-year-old female subject child passed away on the same date. WCDSS had an open services case, due to the subject child being placed in foster care on 9/14/21 after ongoing concerns regarding the mother and father's mental health, and substance and alcohol misuse. Prior to the subject child's hospitalization, she resided with her foster parents. There were no surviving siblings.

WCDSS completed casework and collateral contacts and learned that the subject child had been in remission from a previous cancer diagnosis in 2020; however, in May 2023 it was determined the subject child's cancer had returned and advanced. On 5/6/23, the subject child was brought to the hospital by the foster parents, due to sleeping more than usual. At that time, the subject child's diagnosis was reviewed by medical staff, and her prognosis was poor. The subject child was transferred to the Intensive Care Unit (ICU) due to breathing issues, and comfort care was in place. The subject child began chemotherapy again in mid-June of 2023; however, succumbed to her illness on 6/30/23.

No autopsy was completed, and no death certificate was received by WCDSS. Medical records indicate the subject child was diagnosed with relapsed, progressive Rhabdomyosarcoma of the Central Nervous System.

Bereavement services were offered to the mother and father. The mother was awaiting a return phone call from grief counseling; however, the father had not yet reached out to services. It was unknown at the time of case closure if the parents were engaged in grief counseling. The record did not reflect that bereavement services were offered to the foster parents of the subject child.

PIP Requirement
WCDSS will submit a PIP to the Westchester Regional Office within 30 days of 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A

- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
This was a non-SCR reported fatality; therefore, no determination was made or required.

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:
Casework was commensurate with case circumstances.

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: 06/30/2023 **Time of Death:** Unknown

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

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	Deceased Child	No Role	Female	5 Year(s)
Deceased Child's Household	Foster Parent	No Role	Female	73 Year(s)
Deceased Child's Household	Foster Parent	No Role	Male	71 Year(s)

LDSS Response

WCDSS continually gathered information related to the SC's medical status throughout the open services case, and her return to foster care in 2021.

The SC was first discovered to have a brain tumor in November of 2020, while she was in the care of the BF. The SC received chemotherapy and a craniotomy, along with other intensive medical procedures including the insertion of a gastrostomy tube. The SC was determined to be cancer-free after a routine imaging in October of 2021; however, in February of 2022, it was determined the SC had a new growth on her brain. The SC underwent further treatment including another brain surgery, radiation, and chemotherapy which were successful. In May of 2023, imaging showed the SC had more growths on her brain and her overall prognosis was that she would not live more than a month. The SC was hospitalized on 5/6/23 after the foster parents noticed the SC was sleeping more than usual. The SC was subsequently admitted to the ICU a few days later due to breathing trouble. The SC remained hospitalized, her condition rapidly declined, and she passed away on 6/30/23.

The SC was born with a positive toxicology for illicit substances and was discovered to have a blood clot on her brain. The SC was hospitalized for two months in the Neonatal Intensive Care Unit (NICU) and was removed from the BM's care at the time of her discharge. The SC remained in foster care until she was returned to the BF's care on 10/10/20, where she remained until she returned to foster care on 9/14/21 due to her parents' ongoing substance and alcohol misuse.

WCDSS was in consistent communication with medical staff regarding the SC's medical care and status, all throughout her diagnoses and hospitalizations.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐

All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

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:
The record did not reflect that bereavement services were offered to the FP's following the SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The record did not reflect if bereavement services were offered to the foster parents following the death of the SC.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/12/2021	Deceased Child, Female, 3 Years	Father, Male, 36 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 3 Years	Father, Male, 36 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 3 Years	Mother, Female, 36 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 3 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The SCR report alleged for the past 10 months, the SC was hospitalized due to cancer and was recovering from a bone marrow transplant. The BM and BF had a history of visiting with the SC while under the influence of drugs and/or alcohol. The most recent incident occurred on 9/12/21, in which the BF arrived at the hospital intoxicated and delusional. The BF stated he had been at a food court with the SC, and she ran away, and he could not find her. The BF attempted to go see the SC but was prevented from doing so by hospital security.

Report Determination: Indicated **Date of Determination:** 10/01/2021

Basis for Determination:
On 9/12/21, the BF went to the hospital reporting the SC ran away from him in the cafeteria and he did not know her whereabouts. The SC was in her room asleep, and the BF had not been to visit the SC. The BF was prohibited from visiting the SC and LE was called. The hospital restricted both parents from visiting the SC due to ongoing concerns for

the SC's safety in the presence of the parents, as they appeared under the influence several times. The shelter where the parents resided also reported observing the BM under the influence. The SC was removed from the parents' care on 9/14/21 and an OP was granted in favor of the SC against the parents. The parents were granted supervised visits.

OCFS Review Results:
WCDSS initiated their investigation within 24 hours by contacting the source of the report, interviewing the parents regarding the allegations, and assessing the SC in the hospital. Upon learning of the ongoing concerns regarding the parents' substance misuse, WCDSS petitioned for the removal of the SC. The petition was granted, and the SC was removed from the parents' care on 9/14/21. The RAP did not reflect the BM as a secondary caretaker nor did it include the recent DV history.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP did not identify the BM as a secondary caretaker for the SC, despite her regular visitation with the SC before her removal. The RAP did not identify the previous domestic violence incident that occurred during which the BM physically assaulted the BF.

Legal Reference:
18 NYCRR 432.2(d)

Action:
WCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified in the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/30/2021	Deceased Child, Female, 3 Years	Father, Male, 36 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 3 Years	Father, Male, 36 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 3 Years	Mother, Female, 39 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 3 Years	Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The SCR report alleged that the BM and BF had a history of substance abuse. The BM gave birth to the SC who was born addicted and tested positive for unknown substances, possibly opiates. Shortly after the SC's birth, she was removed from her parents' care due to neglect related to substance abuse. Since then, the SC returned to the BF's care and the BM had supervised visitation. On 6/30/21, the BF was impaired by an unknown substance in the presence of the SC who was medically fragile. The BF was not in a state to adequately care for the SC. The BF's eyes were half closed, he was falling asleep, swaying, slurring his speech, and his pupils were dilated.

Report Determination: Indicated | **Date of Determination:** 08/27/2021

Basis for Determination:
WCDSS substantiated all allegations against the BM and BF. The parents refused to provide toxicology screens, sign releases of information, or comply with WCDSS. The hospital pushed the SC's discharge due to concerns for the SC's safety if discharged to the parents due to the SC's extensive medical needs. The hospital had a record of every incident in which the parents were observed under the influence. The BM was supposed to have supervised visits but would show up unsupervised. The parents were inconsistent with medical training and under the influence to the point that nurses would

not allow the parents to participate because it would be unsafe for the SC.

OCFS Review Results:
WCDSS interviewed the parents after receipt of the initial SCR report; however, the parents obtained an attorney due to the pending neglect petition and refused to cooperate with WCDSS. Therefore, numerous concerns were unable to be addressed with the parents. WCDSS was in communication with the hospital regarding the SC's medical status. The SC was assessed in the hospital where she remained during the investigation. The Safety Assessment did not accurately reflect case circumstances. The parents' substance misuse was not reflected as a safety factor. The safety decision noted factors did not rise to the level of immediate/impending danger, despite court intervention.

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
The Safety Assessment did not accurately reflect case circumstances. The safety factor for substance misuse was not checked. The parents were observed under the influence on multiple occasions while caring for the SC, to the point of interfering with medical treatment. The safety decision stated factors did not rise to the level of immediate/impending danger, despite court intervention.

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

Action:
The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/19/2021	Deceased Child, Female, 2 Years	Mother, Female, 39 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 2 Years	Father, Male, 36 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 2 Years	Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 2 Years	Father, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The SCR report alleged the BM and BF had a history of being impaired by substances while caring for the SC at the hospital. The last known occurrence was on 3/18/21. When the parents were under the influence they would nod off, act erratic, and were unable to adequately focus. On one occasion, the parents danced in the middle of the street, which prevented cars from passing. Two subsequent reports were made regarding the parents using cocaine, the BM's ongoing substance misuse, her erratic behavior, and the parents arguing.

Report Determination: Indicated | **Date of Determination:** 05/18/2021

Basis for Determination:
WCDSS substantiated the allegation of IG against both parents and PD/AM against the BM. The BF admitted the BM visited while he napped. The SC was medically fragile and required extensive 24-hour care. The parents were observed under the influence while caring for the SC and the BM tested positive for cocaine. The case record reflected the BM was referred to inpatient treatment, but the BF tested negative for illicit substances. The parents argued and did not reposition the SC while she was vomiting, placing her at risk of suffocation. The BF arrived at the hospital "inebriated." Hospital security made the BF sleep in the lobby before returning to the SC's room the following morning.

OCFS Review Results:
WCDSS initiated their investigation within 24 hours by completing a face-to-face visit to the hospital in which the family was residing for the SC's medical treatment. WCDSS interviewed the parents regarding the allegations of the report and were in consistent contact with medical staff at the hospital regarding the SC's medical care. The record did not reflect that all concerns discovered during the investigation were addressed. The BM was not interviewed regarding an incident in which she physically assaulted the BF in the presence of the SC, while the SC was actively ill and required intervention to ensure her well-being.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
WCDSS learned of concerns regarding the BM becoming physical with the BF during an argument in the presence of the SC, who was actively vomiting and not positioned correctly. The record did not reflect this was discussed with the BM or that the effect this incident could have had on the SC's immediate well-being was discussed with either parent.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
WCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Issue:
Review of CPS History

Summary:
The CPS history review was not added to the case record until 5/18/21.

Legal Reference:
18 NYCRR 432.2(b)(3)(i)

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/10/2020	Deceased Child, Female, 2 Years	Mother, Female, 38 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 2 Years	Mother, Female, 38 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 2 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 2 Years	Father, Male, 36 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The SCR report alleged the SC slept for an unusual amount of time, appeared lethargic, vomited, and was holding her head. On 11/4/20, medical care was sought. Tests were done on the SC, and the parents were informed if the SC did not feel better to seek further medical treatment. On 11/6/20, the SC still did not feel better and on 11/9/20 the SC was crying and holding her head; however, the parents did not seek medical care. Other individuals sought medical treatment and

testing for the SC, which determined the SC had fluid on her brain, and a tumor that required surgery. There was concern regarding the parents not seeking medical treatment for the SC despite medical advice.

Report Determination: Unfounded | **Date of Determination:** 01/08/2021

Basis for Determination:
The BM reported the SC seemed unlike herself for about a week and saw her pediatrician the week prior, but denied the pediatrician advised the parents to take the SC to the hospital. The SC seemed to improve but began holding her head two days prior to the SCR report. After days the SC's symptoms returned, with additional symptoms. The parents took the SC to the hospital because the SC was holding her head and walking unsteadily. Upon admission to the hospital, the SC was diagnosed with a brain tumor, underwent brain surgery, began chemotherapy, and remained hospitalized. The services case remained open. A substance abuse referral was made for the BM regarding her ongoing substance misuse.

OCFS Review Results:
WCDSS initiated their investigation timely, contacted the source of the report, and completed a face-to-face with the parents and SC. WCDSS was in regular contact with hospital staff regarding the SC's current medical status. The allegation of LMC was predetermined, as the SC's pediatrician who evaluated her the week prior to her hospitalization was not contacted. Additional collaterals including the BM's prior treatment provider and a current service provider aware of the BM's recent substance misuse were not contacted. The RAP and Safety Assessment at the time of case closure did not accurately reflect case circumstances, and the CPS history review was completed untimely.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
The allegation of LMC was predetermined. The BM reported after the SC was initially evaluated by her pediatrician, she experienced multiple episodes of worsening symptoms for days before being hospitalized. WCDSS did not contact all necessary medical collaterals to follow up with the lapse in care or determine if the parents were advised to bring the SC to the hospital sooner, as alleged.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
WCDSS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The record did not reflect that WCDSS obtained medical records from or spoke to the SC's pediatrician who evaluated the SC the week prior to her hospitalization to gather information related to the allegations of the report. WCDSS did not contact the BM's prior substance abuse treatment provider or a community service provider aware of the BM's recent substance misuse.

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

Action:
WCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Pre-Determination/Home Visit

Summary:
Although the SC was hospitalized on the date of the SCR report and hospital staff reported the SC would be hospitalized for months to possibly a year; the SC had previously been residing with the parents in a shelter. The record did not reflect

that WCDSS conducted a home visit to the shelter to assess the SC's living environment prior to being hospitalized.

Legal Reference:

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

Action:

Prior to a determination being made, the investigation must include one home visit so as to evaluate the environment of the child named in the report as well as other children in the same home.

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The Safety Assessment completed at the time of the determination noted no safety factors; however, there was an open services case, family court involvement including a court order prohibiting the BM from being unsupervised with the SC and concern regarding the BM's recent substance misuse in the presence of the SC.

Legal Reference:

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

Action:

The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP listed the BF as the primary caretaker; however, did not list the BM as a secondary caretaker. While the BM was not allowed to be unsupervised with the SC and the BF had custody of the SC, the BM resided in the home, had regular contact with the SC, and acted as a caretaker. The BM had a recent history of MH and substance misuse that would have affected the overall risk rating.

Legal Reference:

18 NYCRR 432.2(d)

Action:

WCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified in the Risk Assessment Profile.

Issue:

Review of CPS History

Summary:

A CPS history check was completed late on 12/21/20. A timely review of the family's CPS history would have provided information pertinent to the SC's recent discharge from foster care and family court orders, including that the BM was not allowed unsupervised contact with the SC.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

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

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

There was one indicated case from 6/8/18 with allegations of IG and PD/AM substantiated against the BM. The SC was

born with a positive toxicology for cocaine, benzodiazepine, buprenorphine, and marijuana. The BM admitted to misusing opiates and cocaine while pregnant with the SC. The SC was removed from the BM and placed in foster. The BM engaged in treatment and the BF was incarcerated at the time.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Family Assessment and Service Plan (FASP)

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

Preventive Services History

The open services case turned from a foster care case to a preventive case from 10/20/20 to 9/14/21. During that time, the SC was in the care and custody of the BF. WCDSS assisted with the SC's medical needs, services related to the BF's substance misuse history, and the BM's ongoing substance misuse; until the BM and BF became uncooperative with WCDSS and the SC was ultimately removed from the BF's care due to ongoing concerns related to alcohol/substance misuse.

Foster Care at the Time of the Fatality

The deceased child(ren) were in foster care at the time of the fatality? Yes
Date deceased child(ren) was placed in care: 09/14/2021
Date of placement with most recent caregiver? 10/19/2021
How did the child(ren) enter placement? Court Order

Review of Foster Care When Child was in Foster Care at the time of the Fatality

	Yes	No	N/A	Unable to Determine
Does the case record document that sufficient steps were taken to safeguard this child's safety while in this placement?	☒	☐	☐	☐
Did the placement comply with the appropriateness of placement standards?	☒	☐	☐	☐
Was the most recent placement stable?	☒	☐	☐	☐
Did the agency comply with sibling placement standards?	☐	☐	☒	☐
Was the child AWOL at the time of death?	☐	☒	☐	☐

Visitation

	Yes	No	N/A	Unable to Determine
Was the visitation plan appropriate for the child?	☐	☒	☐	☐
Was visitation facilitated in accordance with the regulations?	☒	☐	☐	☐
Was there supervision of visits as required?	☒	☐	☐	☐

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?	☐	☒	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource made with required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource in the parent/relative/discharge resource's home made with required frequency?	☒	☐	☐	☐
Were all of the casework contact requirements for contacts with the caretakers made, including requirements for contact at the child's placement location?	☐	☒	☐	☐

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the agency provide the foster parents with required information regarding the child's health, handicaps, and behavioral issues?	☒	☐	☐	☐
Did the provider comply with discipline standards?	☒	☐	☐	☐
Were the foster parents receiving enhanced levels of foster care payments because of child need?	☒	☐	☐	☐
If yes, was foster parent provided a training program approved by OCFS that prepared the foster parent with appropriate knowledge and skills to meet the needs of the child?	☒	☐	☐	☐
Was the certification/approval for the placement current?	☒	☐	☐	☐
Was a Criminal History check conducted? **Date:** 06/01/2018	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:** 06/28/2018	☒	☐	☐	☐
Was a check completed through the Staff Exclusion List? **Date:** 06/15/2015	☒	☐	☐	☐
Additional information, if necessary:				

The SC returned to foster care on 9/14/21, due to ongoing substance and alcohol misuse by the parents. The SC remained in foster care until her death on 6/30/23. A conditional surrender was discussed in 3/2023; however, not pursued due to the SC's dire medical status and poor prognosis prior to her death.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?

☒Yes ☐No

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Between 9/14/21 and the SC's death, there were 97 progress notes entered more than 30 days past their event date.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.
Issue:	Adequacy of monitoring child/family while in foster care
Summary:	During the foster care case, home visits to the foster home were not made with the required frequency, in that the residence was not assessed between 12/23/21 to 5/24/22, and 8/25/22 to 3/6/23.
Legal Reference:	18 NYCRR 441.21
Action:	Casework contacts at the child's placement location are to be scheduled to occur at least once during the first 30 days of placement and at least once every 90 days thereafter, for as long as the child remains in foster care, unless compelling reasons are document why contacts are not possible.

Foster Care Placement History

The SC was removed from the BM's care after birth due to her positive toxicology and the BM's admission of misusing cocaine and opiates while pregnant with the SC. The SC remained in foster care until she was discharged to the BF's care and custody on 10/20/20, at which time the foster care services case became a preventive case. The SC remained in the BF's care until she was removed again on 9/14/21 due to the BM and BF's ongoing substance misuse. The SC remained in foster care until her death.

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: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/13/2021	Adjudicated Neglected	Foster Care Placement to Continue
Respondent:	051301 Other	
Comments:	An Article 10 Neglect Petition was filed against the BM and BF regarding the SC due to ongoing alcohol/substance misuse, while in the presence of and caring for the SC. There was a finding of	

	neglect and the SC's permanency goal was adoption at the time of her death.

Have any Orders of Protection been issued? Yes	
From: 09/14/2021	**To:** 06/30/2023
Explain: A full stay-away Order of Protection was issued after the SC was removed from the parents' care on 9/14/21 and remained in place until the SC's death on 6/30/23. The parents were allowed supervised visitation by WCDSS.	

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