Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-20-003

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

Issue Date: May 29, 2020

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 01/19/2020
Initial Date OCFS Notified: 01/22/2020

Presenting Information

An SCR report alleged on 1/18/2020, the father placed the 3-month-old female subject child on a twin sized mattress on the floor in his bedroom. There was a sheet and a pillow on the bed. The child was placed on her back on a pillow. The father sat on the opposite end of the mattress while he played video games. Ten minutes later, the father checked on the child and found her unresponsive and purple in color. The father contacted EMS, who transported the child to the hospital. The child was brain dead. On 1/19/2020, the child was pronounced deceased. The paternal grandmother was in the home at the time of the incident; therefore, considered an alleged subject.

Executive Summary

This fatality report concerns the death of the 3-month-old female subject child that occurred on 1/19/20. The child died during an open CPS investigation regarding the fatal incident. On 1/18/19, the father found the child unresponsive on a mattress. A report was made to the SCR regarding her death on 1/23/20. The child resided with her parents, 2-year-old sibling, paternal grandmother, aunts (ages 12 and 17 years), and 13-year-old uncle. The children were assessed to be safe in the care of their family.

Westchester County Department of Social Services (WCDSS) contacted law enforcement after learning of the fatal incident. The outcome of the criminal investigation remained unknown; however, law enforcement believed the death was an accident. An autopsy was performed; however, the medical examiner's report was pending at the time this report was written.

The father reported placing the child on top of a pillow that was on a mattress. The father initially said the child was face-down on the mattress, but later said the child was face-up. The father attempted to soothe the child by rocking his foot on the mattress and noticed she was unresponsive and not breathing. He alerted the grandmother, who attempted CPR, and the children called 911. EMS responded and took over resuscitation efforts as the child was transported to the hospital where she was placed on life-support. The grandmother corroborated the father's recollection.

The mother was at work at the time of the incident and had no additional information. The children were in their bedrooms and did not have information regarding the death.

WCDSS gathered information regarding the death from the family, hospital staff and first responders.

Several home visits were completed throughout the investigation, and an abundance of services were offered to and accepted by the parents. The grandmother and her children declined services from WCDSS and obtained assistance through their church. It remained unknown if the father was enrolled in bereavement services. At the time of case closure, the mother was on a waiting list for counseling services.

WCDSS completed Safety Assessments and required reports timely. Although the Safety Assessments were completed timely, they did not accurately reflect information within the case record. WCDSS implemented an appropriate safety plan with the family inhibiting the father to have unsupervised contact with the sibling; however, this was not reflected in the Safety Assessments. Additionally, although the parents and grandmother were provided with written notice of the SCR reports timely, the record did not reflect the fathers of the surviving children were contacted or notified of the SCR report.

The allegation of Lack of Supervision was unsubstantiated against the father. WCDSS documented the investigation did not reveal the father left the child unattended at any time. The allegations of Inadequate Guardianship and DOA/Fatality were unsubstantiated against the father and grandmother. The investigation did not reveal credible evidence that the father's actions or inactions caused the death of the child, or that he placed her at risk of harm. Although the grandmother was in the home, she was not deemed a person legally responsible for the child as she did not have caretaking responsibilities for the child. WCDSS unsubstantiated the allegations of the report and closed the case as the family did not warrant further intervention from WCDSS.

PIP Requirement

WCDSS will submit a PIP to the Spring Valley 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?** Yes

Was the decision to close the case appropriate? Yes

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

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

Explain:

The fathers of the sibling and the paternal aunts/uncles were not contacted regarding the SCR reports.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report

Summary:	Although the adults listed on the reports were provided with written notice timely, the father of the sibling and the father of the paternal aunts/uncle were not provided with written notice of the SCR reports.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	WCDSS will make diligent efforts to contact absent parents of children named in a report and to provide written notice within 7 days of receipt of the report.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Although the interviews with the children and adults in the home were thorough and appropriate, the record did not reflect attempts to contact the absent fathers of the children listed on the SCR reports.
Legal Reference:	432.1 (o)
Action:	WCDSS will make efforts to make casework contacts with biological parents of children named in an SCR report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/19/2020 **Time of Death:** 10:25 AM

Date of fatal incident, if different than date of death: 01/18/2020
Time of fatal incident, if different than time of death: 08:30 PM

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: 09:20 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
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	Aunt/Uncle	No Role	Female	17 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	13 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	12 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	47 Year(s)
Deceased Child's Household	Mother	No Role	Female	21 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

On 1/18/20, WCDSS received a SCR report regarding the fatal incident. The baby was found unresponsive and not breathing by the father and was transported to the hospital where she was placed on life-support until she died on 1/19/20. On 1/23/20, an SCR report was made regarding the death. Within the first 24 hours of investigating the fatal incident, WCDSS noted a CPS history check and assessed the safety of the children. When the fatality report was received on 1/23/20, WCDSS contacted LE and notified the DA of the death. The ME's office was contacted to obtain the autopsy report.

On 1/19/20, a home visit was made. The grandmother said the father fed the baby and attempted to burp her. About 20 minutes later, the father brought the baby into a bedroom. The grandmother did not know how the baby was put to sleep, but said the baby slept on her stomach. The father was in another room when the baby cried, and the father tended to her. About 20 minutes later, the father yelled to the grandmother that the baby was unresponsive. The grandmother rubbed the baby's chest, but she did not wake up. 911 was called. The grandmother could not remember other information. At that time, a safety plan was created with the grandmother noting the sibling would be supervised around the father until further notice. The sibling was observed to be free from any visible marks or bruises.

The parents were initially interviewed on 1/20/20. The father said he placed the baby face-down to burp her, and when she burped, he placed her face-up with a pillow on each side of her. He rocked the mattress with his foot before noticing the baby was unresponsive. The baby was wearing a 1-piece snow suit at the time.

On 1/23/20, the parents were interviewed again. The mother was not home at the time of the incident. She was told the baby was unresponsive and came home. EMS was tending to the baby. The mother rode with the baby to the hospital while EMS performed CPR. She said the baby acted normally on the day prior to her death. The father said on 1/18/20, he cared for the baby while the mother worked. He fed the baby between 8:00-9:00 PM, burped her and placed her on her stomach in a Pack 'N Play. He left the room, and soon the grandmother said the baby was crying. The father went in the bedroom and laid the baby on her stomach on a twin sized mattress with a sheet and blanket, and placed the baby on top of a pillow. He sat on the opposite side of the bed and bounced his legs to soothe the baby while he played on his phone. Around 8:30 PM, he noticed the baby was not making noise and saw she was blue. He shook the baby to wake her. He yelled for the grandmother, who attempted CPR. The children were told to call 911.

On 1/27/20, the children said they were in their rooms at the time the baby was found unresponsive. The 17-year-old aunt said the baby acted normally prior to the fatal incident. The 13-year-old uncle heard the father cry and yelled for the grandmother and called 911. The other children had no additional information.

WCDSS obtained records from LE, EMS and the hospital. LE arrived at the home and observed the baby to be unresponsive. Although LE would not provide their records to WCDSS, they said the death appeared to be an accident and the baby could have choked. EMS said the baby was unresponsive and limp and transported her to the hospital. The

hospital staff said the baby was in cardiac arrest and put on a ventilator. The parents withdrew care due to the baby's poor prognosis.

An abundance of services were offered to the family including Victim's Assistance Services, grief counseling and burial assistance. The mother accepted services; however, she was placed on a waitlist for counseling. The grandmother, aunts and uncle found support through their church. It was unknown if the father engaged in bereavement services.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? No
Comments: WCDSS attempted to coordinate investigative efforts with law enforcement; however, law enforcement was not forthcoming with information gathered.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The death was referred to an OCFS-approved Child Fatality Review Team during the course of the investigation.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053921 - Deceased Child, Female, 3 Mons	053924 - Grandparent, Female, 47 Year(s)	DOA / Fatality	Unsubstantiated
053921 - Deceased Child, Female, 3 Mons	053922 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated
053921 - Deceased Child, Female, 3 Mons	053922 - Father, Male, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
053921 - Deceased Child, Female, 3 Mons	053924 - Grandparent, Female, 47 Year(s)	Inadequate Guardianship	Unsubstantiated
053921 - Deceased Child, Female, 3 Mons	053922 - Father, Male, 23 Year(s)	Lack of Supervision	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐

Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☐	☒	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
Despite efforts by WCDSS, law enforcement did not collaborate during the investigation into the death with WCDSS. The biological fathers of the surviving children were not documented to have been contacted.

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?	☐	☐	☒	☐

Explain:
Although some of the children were observed following the death, the record did not reflect how the safety of all the children was assessed within the first 24 hours of the fatality investigation. The sibling was documented to be safe in the care of her mother and grandmother.

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: An abundance of services were offered to the family including bereavement services and burial assistance.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: Although the mother and paternal grandmother agreed to a safety plan which included supervising the children around the father, the record did not reflect the father was made aware of the safety plan. Although the safety plan created by WCDSS was appropriate with regard to case circumstances, the safety plan was not accurately documented in the Safety Assessment tool.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐

Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☒	☐	☐	☐	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The 2-year-old sibling was referred to Early Intervention as a county protocol. The mother accepted services; however, was put on a waitlist. The paternal grandmother and the aunts/uncles declined services as they had a strong support system through their church. It was unknown if the father participated in bereavement services.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
The children were offered services in response to the fatality, but the services were declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The grandmother and father were offered services in response to the fatality. The mother accepted services and was placed on a waitlist.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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? 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
☐ Had heavy alcohol use
☐ Smoked tobacco

☐ Experienced domestic violence
☐ Used illicit drugs
☒ Was not noted in the case record to have any of the issues listed

Infant was born:
☐ Drug exposed
☐ With fetal alcohol effects or syndrome
☒ With neither 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)
10/16/2018	Aunt/Uncle, Male, 12 Years	Grandparent, Female, 46 Years	Educational Neglect	Unsubstantiated	Yes

Report Summary:
An SCR report alleged the paternal grandmother was unable to make certain the uncle attended school on a consistent basis for the 2018-2019 school year. The uncle cut school, left early or did not attend school. On 10/16/18, the uncle was found at a library during school hours. Due to his absences, the uncle failed his classes for the first marking period.

Report Determination: Unfounded **Date of Determination:** 12/14/2018

Basis for Determination:
The investigation was unfounded as there was no credible evidence to substantiate the allegation. The investigation revealed the grandmother woke up the uncle for school on a regular basis; however, she left the country for two weeks. During her absence, the uncle skipped school and made her believe he attended. The uncle's attendance improved when the grandmother was made aware, and the uncle did not suffer academically.

OCFS Review Results:
The investigation was initiated timely and the children were observed. Home visits were conducted. The 7-day Safety Assessment was completed timely and accurately. The Safety Assessment at the time of case closure was inaccurate. The adults on the case were not provided with written notice. The father(s) of the children were not documented to be contacted or notified in writing regarding the SCR report. The record did not reflect the family was interviewed regarding overall safety and risk; the investigation was allegation driven. A CPS history check was not documented.

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

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
The Safety Assessment completed at the time of case closure did not accurately reflect case circumstances. The investigation revealed the grandmother did not provide adequate supervision while she was out of the country; however, she returned home and the safety factor was selected at the time of case closure.
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 with regard to safety.

Issue:
Failure to provide notice of report
Summary:

Although the grandmother was provided with written notice of the SCR report, she was provided with the notice on 12/14/18. The father(s) of the children and the adults (siblings to the uncle) who resided in the home were not provided with written notice.

Legal Reference:

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

Action:

WCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:

The record did not reflect the father(s) of the children were interviewed.

Legal Reference:

432.1 (o)

Action:

A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Interviews should include an assessment of overall safety and risk.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The case was predetermined regarding safety and risk as efforts were not made to interview all children, adults or parents. The interviews with the family were solely focused on the reported concern. Although the home members were seen, the record did not reflect all home members, including children, were interviewed regarding safety and risk. The conversations documented were allegation driven.

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 on-going assessment of safety and risk throughout the investigation. The basis for the decisions on the safety assessment will be documented.

Issue:

Review of CPS History

Summary:

The record did not reflect a CPS history check was completed.

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

06/03/15- 07/14/15 The paternal grandmother was unsubstantiated for the IG, IF/C/S and LMC of the uncle.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

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