Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-21-039

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

Issue Date: Mar 21, 2022

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: 2 year(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 09/26/2021
Initial Date OCFS Notified: 09/26/2021

Presenting Information

An SCR report was received which stated that on the morning of 9/26/21, the mother went to wake the subject child and found her unresponsive in her bed, face down with blood under her nose. The mother called police immediately. When emergency services arrived, the child did not have a pulse. The child was transported to the hospital where she was pronounced deceased. The child was otherwise healthy and the mother had no explanation for her death.

Executive Summary

This fatality report concerns the death of a two-year-old female subject child that occurred on 9/26/21. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother. Westchester County Department of Social Services (WCDSS) received the report and investigated the child's death. An autopsy was performed; however, the final report had not yet been issued at the time of this writing. A preliminary report noted the child died due to ingesting a corroded 3-volt lithium battery, which led to a blood clot and erosion of the esophagus.

At the time of the child's death, the child resided with her mother and seven-year-old sibling. The child's father's whereabouts were unknown, and it was determined he had no contact with the subject child. The subject child had several half-siblings that lived in another county, with whom she also had no contact. Through interviews with family members and law enforcement, WCDSS discovered that from 9/14/21 until the date of her death, the subject child had complained of throat and stomach pain. Additionally, the child had fluctuating high fevers, labored breathing, and was lethargic with a decreased appetite. The mother sought medical attention for the child on 9/14/21 and 9/16/21 and was informed by physicians the child had a virus and to give fever reducers as needed. On 9/20/21, the child attended a dentist appointment, and was found to have molars coming in. The dentist informed the mother that this could be causing the fluctuating fevers the child was experiencing. From 9/21/21 to the date of her death, the child was reported to have been acting more like herself with her appetite improving. At approximately 8:30AM on 9/26/21, the mother found the child unresponsive in her bed, with dried blood under her nose. Emergency services were called, and the child was transported to a local hospital where she was declared deceased.

WCDSS spoke with family members and collateral sources, which included those who cared for the child while the mother worked and service providers from the community. It was determined the child swallowed the battery while at a maternal aunt's house on 9/14/21 or 9/15/21, as the battery had been in a dog collar that had been chewed apart by the aunt's puppy. The aunt was unaware the battery had fallen out of the collar and was accessible to the subject child. Law enforcement found no criminality regarding the child's death and ruled it an accident. WCDSS did not find evidence to substantiate the allegations in the report, as the mother acted appropriately by seeking medical care when the child appeared ill. The surviving sibling was interviewed and deemed safe, and the case was unfounded and closed.

PIP Requirement
This review resulted in a citation related to casework practice. In response, WCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) WCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
WCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving sibling.

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 case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The record did not reflect any efforts to speak to the surviving sibling's biological father, despite recent CPS history noting he and the sibling were having visitation.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	WCDSS will make efforts to interview all persons named in a report, face to face, who may have been present during what was alleged in the report, and/or may have information pertinent to the safety and well-being of children that reside in the home, including absent biological parents.
Issue:	Failure to provide notice of report

Summary:	The record did not reflect the biological father of the surviving sibling was provided a notice of existence letter regarding the investigation.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	WCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/26/2021 **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? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 7 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Other Household 1	Father	No Role	Male	25 Year(s)

LDSS Response

On 9/26/21, WCDSS received the SCR report regarding the death of SC, which occurred on that same date. WCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team.

On 9/26/21, WCDSS went to the hospital following the incident to assess SS' safety, as he was there with family. SS was interviewed and reported he was at his father's house and not present for what occurred. He denied any safety concerns in the home and was deemed safe.

On 10/7/21, WCDSS met with SM at her residence. SS, MGM, MA, and one of SM's service providers were also present. SM reported that SC began feeling ill on 9/14/21, while SC was with MA and SM was at work. SM said MA called her to tell her SC had a fever and was vomiting, so SM brought SC to the urgent care where SC was diagnosed with a virus. SM said she was told to give SC fever reducers as needed; however, SC continued to have a fever, was lethargic, and complained of throat pain. SM said that on 9/16/21, she brought SC to the ER, where she was given fluids and again diagnosed with a virus; SC was discharged that same day and SM was told to follow up with her pediatrician. SM reported that on 9/20/21, SC had a dentist appointment and SM was informed SC had molars growing in, which could cause fevers. SM stated she assumed the fevers had been from that, so she did not seek any further medical care for SC. SM explained MGM cared for SC from 9/21/21 until 9/24/21, and MGM said SC's fever would fluctuate, but she was acting fine, albeit not eating as much as normal. SM said she last saw SC alive when she checked on her around 1:00AM on 9/26/21; SM found SC unresponsive in her bed at 8:30AM that morning. All family members denied SC had any underlying medical conditions. The home was observed, and no hazards were noted. SS was also observed and deemed safe.

LE informed WCDSS that the ME found SC had swallowed a 3-volt lithium battery. The ME noted SC suffered a blood clot as a result of the corrosion to the battery, and there was erosion to SC's esophagus as well. LE then informed WCDSS that upon interviewing SM, it was discovered MA had a puppy, whose collar took a 3-volt lithium battery. The puppy had chewed off the collar, and MA had not realized the battery had fallen out when she threw the collar away. LE concluded SC swallowed the battery when she was at MA's home on either 9/14 or 9/15, and this was why SC was complaining of throat pain. LE explained that from their interviews, it appeared none of the family members were aware SC had access to a battery until after the autopsy.

WCDSS assigned ACS a secondary role on the case, as SC's BF resided in that jurisdiction. Attempts to meet with BF were made but unsuccessful. WCDSS spoke with BF via phone, who confirmed he did not have any physical contact with SC but provided support financially. He reported he had moved but would not provide WCDSS with an updated address. BF also declined to meet with WCDSS in person. WCDSS confirmed SM had an active OP against BF, and the two had no contact.

Throughout the investigation, WCDSS spoke with family members and collateral sources, including MGM, MA, SSs' school, the pediatrician, and service providers. There were no concerns noted surrounding SM or her care of the CHN. Historical cases noted SS and SC did not share the same father, and SS's BF was not the same person listed as his legal father on his birth certificate. Although WCDSS attempted to reach SS's legal father, the record did not reflect WCDSS made any attempts to contact SS's BF. LE ruled the death accidental and there were no charges brought against the caretakers. Services were offered to the family but declined. WCDSS determined SM acted appropriately after SC began showing symptoms of illness by seeking medical attention on more than one occasion. WCDSS noted SM's actions did not contribute to SC's death, and the investigation was unfounded and closed.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: Pending

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: This fatality investigation was conducted by the Westchester County MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was referred to the Westchester County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059807 - Deceased Child, Female, 2 Yrs	059809 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
059807 - Deceased Child, Female, 2 Yrs	059809 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
WCDSS interviewed the family and appropriate collateral sources. The subject child's father refused to meet with WCDSS face-to-face; however, WCDSS spoke with him via phone. Progress notes and other documentation were completed and entered timely.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: WCDSS offered the family appropriate services in response to the subject child's death.				

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:
The surviving sibling did not need to be removed as a result of this fatality report.

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:
WCDSS offered the family referrals for services following the fatality. The mother and surviving sibling were already engaged in services within their community.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
WCDSS provided the mother with service referrals for the surviving sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the

fatality? Yes
Explain:
WCDSS provided the mother, father, and other caregivers with service referrals following the fatality.

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?	Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/03/2021	Sibling, Male, 6 Years	Other Adult - SS's BF, Male, 23 Years	Inadequate Guardianship	Far-Closed	No

Report Summary:
This SCR report was received with concerns while on visitation with his BF, SS was physically abused, and BF hit SS in the chest with excessive force. It was unknown if SS sustained any injuries as a result of BF's actions. SM was not aware of the abuse.

OCFS Review Results:
This investigation was appropriately tracked as FAR. SM and SS were interviewed. SM had full custody of SS and BF had sporadic visitation. SS initially stated BF hit him in the chest as punishment the last time he was at his house; however, later, SM reported she felt SS had lied about the incident because he did not like to be separated from her. SS visited with BF twice during the investigation and reported no further incidents or concerns. BF denied the allegations. SC was observed and deemed safe with SM. SS and SC were up to date medically and no concerns were noted by collateral sources surrounding SM's care of the CHN.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/13/2020	Deceased Child, Female, 5 Months	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 5 Years	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	

Report Summary:
This SCR report was received with concerns that on 1/12/20, SC's BF was physically aggressive toward SM in the presence of SC and SS. The CHN did not sustain any physical injuries.

Report Determination: Indicated **Date of Determination:** 03/10/2020

Basis for Determination:
WCDSS interviewed family and collateral sources. SM reported she and BF ended their relationship, but BF would continue showing up where she was and causing problems. SM stated BF punched her in the lip and they got into an argument, but the CHN did not witness this. BF denied any altercations happened with the CHN present. SS disclosed witnessing BF hit SM in the lip. SM obtained an OP on 1/13/20, but it was vacated on 2/26/20. BF's whereabouts were unknown at the time of case closure. Safe sleep practices were reviewed, and services were offered and accepted, but SM never engaged. Case was indicated and closed.

OCFS Review Results:
This investigation met all statutory requirements.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/07/2019	Sibling, Male, 5 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 5 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 2 Months	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 2 Months	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 5 Years	Day Care Provider, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Day Care Provider, Female, 39 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 2 Months	Day Care Provider, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 2 Months	Day Care Provider, Female, 39 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 5 Years	Father, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Father, Male, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 2 Months	Father, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 2 Months	Father, Male, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 22 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Male, 5 Years	Father, Male, 24 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that SM and BF were smoking marijuana daily in the presence of SC and SS. SM and BF would become impaired while caring for the CHN, and the CHN had access to the drugs and drug paraphernalia. On an unknown date, SS ingested some marijuana. In September 2019, SM and BF were impaired when SS fell and hit his head. As a result, SS sustained scratches to his forehead, and SM and BF did not seek any medical

attention for SS. Further, the CHN's babysitter was also using drugs while watching the CHN; SM and BF were aware and allowed this to occur.

Report Determination: Unfounded | **Date of Determination:** 01/06/2020

Basis for Determination:
BF was involved in an open foster care case regarding his 2 other CHN, with a goal of TPR. SM and BF said they smoked marijuana but not in front of the CHN. SS reported SM and BF smoke in the hallway and was able to describe marijuana. Both refused to drug test. The CHN went to daycare and did not have a babysitter in the home. The daycare provider denied the allegations and any concerns regarding SM and BF's care of the CHN. There was no evidence SS ingested drugs or was injured to the point of needing medical care. SS was noted to be very hyperactive. There was no negative impact to the CHN. The home was safe, and all their needs were being met. WCDSS unfounded and closed the case.

OCFS Review Results:
NOEs were not delivered until 1/3/20.

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

Issue:
Failure to provide notice of report

Summary:
Notice of Existence letters were not delivered until 1/3/20.

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

Action:
WCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/09/2019	Deceased Child, Female, 1 Days	Mother, Female, 22 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Female, 1 Days	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
This SCR report was received with concerns SM gave birth to SC on 8/8/19 and tested positive for marijuana. SM admitted to using the drug during her pregnancy.

OCFS Review Results:
This investigation was appropriately tracked as FAR and a plan of safe care was completed. WCDSS did not discuss the FAR track with the family, nor did they receive consent for the use of FAR. The record did not reflect that WCDSS educated the parents surrounding safe sleep practices. Providers had concerns surrounding possible DV between BF and SM, and BF was on probation for DV against the BM of his other CHN; however, DV was never discussed with the family. The notes did not reflect the family engaged in the FLAG process.

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

Issue:
FAR-Failure to Address Reported or Identified Concerns

Summary:
Although service providers expressed concerns DV was occurring in the home, and WCDSS was aware BF was on probation for DV incidents where he was the aggressor, the record did not reflect that DV was discussed with the family.

Legal Reference:
18 NYCRR 432.13 (a)(3)(iii)
Action:
When a report alleging maltreatment of a child is assigned to the family assessment response track, WCDSS must engage the family in an assessment of the concerns reported to the State Central Register, any family-identified needs and concerns that may impact the safety or risk of children, and the family's strengths and resources that could be engaged to address the identified concerns.

Issue:
FAR-Inappropriate Determination of CPS/FAR Track
Summary:
The record did not reflect that information surrounding the FAR process and how it differed from the investigative track was discussed with the family, nor was there any documented familial consent to utilizing the FAR track.
Legal Reference:
18 NYCRR 432.13 (c); 18 NYCRR 432.13(e)(2)(ii)(a-d)
Action:
WCDSS must provide the family with information about FAR to aid them in making an informed decision about whether to accept assignment of the report to the FAR track.

Issue:
FAR-Timely/Adequate Family-Led Assessment Guide
Summary:
The record did not reflect WCDSS informed the family of the FLAG, or engaged the family in a family-led assessment.
Legal Reference:
18 NYCRR 432.13 (e)(2)(iii)-(v)
Action:
WCDSS must engage the family in an examination of the issues of concern as well as the family's strengths and needs. The assessment must be conducted using a Family Led Assessment Guide (FLAG), as specified by OCFS. The assessment should be conducted in accordance with the principles and practices of FAR.

Issue:
Failure to provide safe sleep education/information
Summary:
The record did not reflect WCDSS educated the parents surrounding safe sleep practices.
Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1
Action:
WCDSS will provide information on sleep safety to the parents and caretakers of infants whom they encounter, and see that necessary steps are taken to provide safe sleeping conditions for the children in their care.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/23/2019	Sibling, Male, 4 Years	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
This SCR report was received with concerns BF was physically abusive toward SM in the presence of SS. On an unknown date, BF hit SM in the face and caused her glasses to fall off. It was unknown if SS had ever been harmed as a result of the incidents.

Report Determination: Unfounded | **Date of Determination:** 06/05/2019

Basis for Determination:
WCDSS interviewed family members and collateral sources. BF did not reside in the home with SM and SS, and SM and BF denied the allegations. SS reported he was not afraid of anyone in the home, and he was observed to be free from marks/bruises. Providers working with the family had no concerns surrounding DV or SM's care of SS. There were no police reports regarding any DV incidents between SM and BF. WCDSS found no evidence to support the allegations and unfounded and closed the case.

OCFS Review Results:
WCDSS did not fully address the allegations in the report with SS. Although SS reported he was not afraid of anyone in the home, WCDSS did not ask questions regarding the incident described in the SCR narrative or questions specific to domestic violence.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
WCDSS did not fully address the allegations in the report with SS. Although SS reported he was not afraid of anyone in the home, WCDSS did not ask questions regarding the incident described in the SCR narrative or questions specific to DV.

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

Action:
Prior to making a determination, WCDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/27/2018	Sibling, Male, 4 Years	Mother, Female, 21 Years	Excessive Corporal Punishment	Unsubstantiated	Yes
	Sibling, Male, 4 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received with concerns SM was hitting SS with a belt as a form of discipline, and the hitting was so excessive, SS would not discuss it. When mentioned, SS would cover his ears in fear and refuse to talk about it.

Report Determination: Unfounded **Date of Determination:** 01/25/2019

Basis for Determination:
WCDSS interviewed family and collaterals. SS stated SM hit him with a belt but did not provide further details. SM reported she had threatened SS with a belt before but did not him with it. SS was free from marks and bruises. SM was engaged in services in her community, including a therapist for herself and SS, an after-care worker, and services for SS through his school. Collateral sources had no concerns. WCDSS did not find evidence to support the allegations. The investigation was unfounded and closed, and the family remained engaged with services.

OCFS Review Results:
The record did not reflect any attempts to contact either SS's BF or legal father.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:

The record did not reflect any attempts to contact either SS's BF or legal father.

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.

[redacted]

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

From 2015 to 2018, the mother was named as a subject in four CPS investigations with common allegations of IG, PD/AM, CD/AM, and IF/C/S. Of those investigations, two were indicated.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A services case was opened in June 2015 after SM could not provide an appropriate home environment for herself and SS and were placed in a supervised independent living program through DSS. SM signed out of the program after securing safe housing for herself and SS and remained engaged in community-based services. The case was closed in December 2015.

A services case was opened in July 2014 after SM, who was 17 years old at the time, was placed in an alternatives for young mothers program. SM was pregnant with SS, and there was ongoing DV between SM and SS's BF. After exhausting other services which were unsuccessful in helping SM, MGM voluntarily placed SM into foster care so SM could receive the services she needed to address the DV and to assist with the care of SS after his birth. SM aged out of care, secured her own housing, and engaged in community-based services. The services case was closed in April 2017.

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