Child Fatality Report

Report Identification Number: NY-16-074

Prepared by: New York City Regional Office

Issue Date: Mar 21, 2017

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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 07/20/2016
Initial Date OCFS Notified: 07/20/2016

Presenting Information

On 7/20/16 and 7/21/16, the SCR received a total of seven reports regarding the death of the SC. Five of the seven were registered as duplicate reports. One of the reports included the allegations I/F/C/S and IG of the SC and his siblings.

The reports noted the parents resided at a Comfort Inn motel that was converted into a family shelter. The reports alleged the parents were home with their three children when the SC was found by the father, unresponsive in his carseat. The reports alleged the children were "covered in urine and feces" and the home was in a "deplorable" condition. The reports also alleged the father had fed the SC and minutes later when he returned to check the child, the child was unresponsive. The reports stated the SC was born premature but had no pre-existing medical conditions. There was no information as to the cause of death.

Executive Summary

The SC was 5 months old at the time of his death. As of 1/13/17, the ME has not issued the autopsy report or provided a preliminary cause of death.

The parents were known to ACS and to the Westchester County Department of Social Services (WCDSS) as the subjects of eight reports registered between 3/3/14 and 1/7/16. The parents had a history of unstable housing and after being evicted from an apartment in Westchester County they relocated to a family shelter in New Jersey (NJ). WCDSS referred the family to the NJ Division of Youth and Family Services (DYFS). However, at the time of the fatality, the family was residing in a family shelter in Kings County. ACS has not confirmed the date the family entered the shelter system in N.Y.

On 7/20/16, the SCR registered two reports with allegations of DOA of the SC; and IF/C/S and IG of the SC and the surviving siblings by the parents.

According to the parents, on 7/20/16, they fed the SC at 6:00 A.M. and again at 10:00 A.M. The parents stated they placed the SC to sleep in his car seat. The mother covered the SC with towels; one was placed on the SC's lap and the other covered his upper body. The mother then placed a blanket over the car seat. The SC was wearing pajamas with his feet enclosed. The parents said they checked the SC at about 11:00 A.M. and found the SC blue and unresponsive. The parents called 911 at 11:19 A.M., after their attempts to administer CPR failed. Once EMS arrived at the case address they continued CPR and transported the SC to Lutheran Hospital where he was pronounced dead at 11:54 A.M. There were several discrepancies concerning the parents accounts; however, ACS has not addressed the inconsistencies.

ACS documented the family's unit at the shelter had two twin size beds and two cribs. The parents reported the SC and the older sibling were placed to sleep in one crib and the 1-year old sibling was put to sleep in the second crib. The parents indicated they had a third crib, but it had been removed from the room because the lack of space presented a fire hazard. ACS did not establish whether the family's usual sleeping arrangement was adequate or consult with the shelter staff about the lack of cribs for the three children.

The NYPD detective who first observed the home indicated there were soiled clothes throughout the room and prepackaged food for the children. The NYPD also noted there were no safety hazards in the room.

The two surviving siblings were taken to Maimonides Hospital where they arrived dirty and "covered in feces." However, they did not have any marks or bruises. The siblings were admitted for a detailed medical examination, and discharged on 7/22/16.

On 7/21/16, ACS held a Child Safety Conference (CSC) and as a result determined the need to file an Article Ten Neglect Petition for the removal of the siblings.

On 7/22/16, ACS filed the Article Ten Neglect Petition and the surviving siblings were remanded and placed in the custody of the Commissioner of ACS under the supervision of the Children's Aid Society agency. The siblings were placed into a non-kinship foster home where they remain. The parents continue to have supervised visits with the children and are complying with services.

Neither the medical staff or the NYPD believed the parents had intentionally hurt the SC. No arrest has been made pending the results of the ME's report. The collateral contacts and family members who were interviewed stressed the parents had limited cognitive skills. Family members emphasized the parents were in need of supportive services.

On 2/24/17 the ME informed ACS the cause of the child's death was interstitial pneumonia of unknown etiology and the manner of death was natural.

As of 3/21/17, ACS has not yet made a determination for this fatality.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Adequacy of Progress Notes
Summary:	There were gaps in documentation in the recording of investigative activities. In addition, there were discrepancies in accounts obtained from the parents and others that were not resolved by the Specialist.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	As of 1/17/17, ACS had not contacted the source for each of the 7 reports registered with the SCR. This is well over the 60 day period to complete an investigation.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS did not make contact with the children's pediatrician or former service providers to assess the specific services needed and/or the parents ability to comply with the needed services.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-Hour Safety Assessment was not approved timely. The safety decision was correct and the siblings were removed; however, on the safety assessment instrument ACS documented there were no safety factors.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 7 day safety assessment was approved timely, but several safety factors were not consistent with

	the case circumstances.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/20/2016 **Time of Death:** 11:54 AM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 11:19 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 15 Minutes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim		5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)

LDSS Response

Following the fatality reports, ACS conducted the investigations simultaneously. ACS contacted the NYPD, medical staff, ME, shelter staff and family members.

ACS had discussed the case with the ME on several occasions. However, there was no inquiry to explore whether the SC could have been suffocated by the blanket the mother reported was over the SC's face at the time of discovery.

Neither the NYPD or the ME have any concerns that the parents intentionally hurt the SC.

The parents stated they had an appointment at the Prevention Assistance and Temporary Housing (PATH) office on 7/19/16 and when they returned to the shelter they cleaned the children and prepared them for bed. The parents' time frame for this event was not consistent. The children were placed to sleep by 12:00 A.M. The SC was placed to sleep with the oldest sibling in a crib and the one year old sibling was placed to sleep in the second crib. The father said he placed the SC to sleep with the oldest sibling because this sibling did not move while he slept.

According to the father, at about 6:00 A.M., he gave the SC 8 ounces of formula mixed with wheat cereal and baby food (carrots). The father noted this mix with the formula was approved by the doctor. The father said he placed the SC in the car seat after he fed the child. The mother covered the SC with 2 towels and placed a blanket over the car seat to keep the SC warm. The parents indicated the temperature in the room was 68 degrees Fahrenheit and they changed it to 78 degrees Fahrenheit. The location of the car seat was not specified.

The father said at about 10:30 A.M., he attempted to give the SC another bottle of formula, but the SC did not feed. The father went back to bed. Fifteen minutes he checked the SC and found the SC not moving. The father stated he attempted CPR, but the SC did not respond. The father called 911 and was directed by the operator to initiate CPR. Once EMS arrived, they continued CPR and transported the father and SC to the hospital where the child died.

ACS contacted the social worker (SW) from Westchester Medical Center who was assigned to work with the parents shortly after the 1-year-old was born. The SW's assessment of the parents was they were not capable of meeting the children's basic medical or social needs. The SW noted the mother had some "delay" and the father was always angry and controlling; the mother would "follow the father's lead"; it was suspected the father was using drugs but he denied the allegation and refused a drug screening; the father would also come to the hospital with a foul odor and the family was always covered in dog hair. The SW also noted the father was not consistent in keeping the children's medical appointments.

On 7/21/16, ACS held a CSC and invited the medical staff from Maimonides Medical Center who indicated the siblings remained at the hospital for medical clearance. There were no medical concerns about the siblings upon discharge.

ACS filed an Article 10 Neglect Petition concerning the siblings and they were remanded to the custody of the Commissioner of ACS. Therefore, they were placed in non kinship foster care following their discharge from the hospital. The parents followed Family Court's orders and visited the siblings under supervision. The parents initially moved to NJ with relatives and then returned to NY and reentered the shelter system. The children are receiving services.

ACS did not verify with the shelter staff all the information provided by the parents concerning the events leading to the SC's death. The children's pediatrician and former providers were not contacted. In addition, while the mother has been repeatedly described as having "delays," it was not clear whether ACS verified a diagnosis.

On 2/24/17, the ME reported the cause of death as interstitial pneumonia (unknown etiology) and the manner of death as natural.

As of 3/21/17, there had been no arrest concerning the SC's death.

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: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: The investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
030021 - Deceased Child, , 5 Mons	030023 - Father, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Pending
030021 - Deceased Child, , 5 Mons	030022 - Mother, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Pending
030021 - Deceased Child, , 5 Mons	030022 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Pending
030021 - Deceased Child, , 5 Mons	030023 - Father, Male, 26 Year(s)	DOA / Fatality	Pending
030021 - Deceased Child, , 5 Mons	030023 - Father, Male, 26 Year(s)	Inadequate Guardianship	Pending
030021 - Deceased Child, , 5 Mons	030022 - Mother, Female, 25 Year(s)	DOA / Fatality	Pending
030024 - Sibling, Male, 2 Year(s)	030023 - Father, Male, 26 Year(s)	Inadequate Guardianship	Pending
030024 - Sibling, Male, 2 Year(s)	030022 - Mother, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Pending
030024 - Sibling, Male, 2	030022 - Mother, Female, 25	Inadequate Guardianship	Pending

Year(s)	Year(s)		
030024 - Sibling, Male, 2 Year(s)	030023 - Father, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Pending
030025 - Sibling, Male, 1 Year(s)	030023 - Father, Male, 26 Year(s)	Inadequate Guardianship	Pending
030025 - Sibling, Male, 1 Year(s)	030023 - Father, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Pending
030025 - Sibling, Male, 1 Year(s)	030022 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Pending
030025 - Sibling, Male, 1 Year(s)	030022 - Mother, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Pending

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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Other	☐	☐	☐	☒
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:

There were 7 reports concerning the SC's death; however, as of 1/13/17 ACS did not contact the source of each report.

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 safety 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:
The 24 hour safety assessment was not approved timely. Also, the safety decision was correct and the siblings were removed, but ACS noted there were no safety factors. The 7 day safety assessment was approved timely, but several safety factors were not consistent with the case circumstances. There was no 30 day "Alleged Child Fatality" safety assessment completed.

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in	☒	☐	☐	☐

foster care at any time during this fatality investigation?				
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: N/A				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/22/2016	There was not a fact finding	There was not a disposition
Respondent:	030023 Father Male 26 Year(s)	
Comments:	On 7/22/16, an Article Ten Neglect petition was filed in Kings County Family Court and a remand was granted with Court Ordered Supervision. The father reported he was a descendant of the Cherokee Indian Tribes. However, during the compliance conference on 9/23/16, the FCLS received word from the three Cherokee Indian Tribes and they had no record of the family or the children belonging to their nations. FCLS provided additional information and two tribes responded with the same information and will not accept the family's case. The fact finding has been scheduled for 1/13/16 and the permanency hearing for 1/23/17.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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	☐	☐	☐	☐	☐	☒	☐

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:
The siblings received medical examinations, were medically cleared and placed into foster care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The parents did not have immediate needs related to the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? No
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
☐ Experienced domestic violence
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ 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)	Status/Outcome	Compliance Issue(s)
01/07/2016	13557 - Sibling, Male, 16 Months	13555 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	No
	13558 - Sibling, Male, 2 Years	13555 - Mother, Female, 24 Years	Lack of Medical Care	Unfounded	
	13557 - Sibling, Male, 16 Months	13556 - Father, Male, 25 Years	Inadequate Guardianship	Unfounded	
	13558 - Sibling, Male, 2 Years	13556 - Father, Male, 25 Years	Lack of Medical Care	Unfounded	
	13557 - Sibling, Male, 16 Months	13555 - Mother, Female, 24 Years	Lack of Medical Care	Unfounded	
	13558 - Sibling, Male, 2 Years	13555 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	
	13557 - Sibling, Male, 16 Months	13556 - Father, Male, 25 Years	Lack of Medical Care	Unfounded	
	13558 - Sibling, Male, 2 Years	13556 - Father, Male, 25 Years	Inadequate Guardianship	Unfounded	

Report Summary:

The report alleged the 2 year old sibling had a history of failure to thrive and had undergone several surgeries for his medical condition. It was noted the parents had not followed up with appointments for the sibling since 12/23/15, which placed the sibling at risk of regression.

The mother continued to be pregnant. This was a high risk pregnancy and prior to relocatng to NJ, she was recieving pre-natal care in Westchester.

Determination: Unfounded

Date of Determination: 01/12/2016

Basis for Determination:

WCDSS unsubstantiated the allegations of LMC and IG of the 2 year old sibling by the parents. WCDSS based their decision on the fact that the family had relocated to NJ and did not investigate the allegations of the report.

OCFS Review Results:

On 1/7/16, WCDSS called the hotline in NJ to report the concerns involving the family. DYFS accepted the report and confirmed the family was residing at a shelter. WCDSS noted the concerns involving the family were discussed with DYFS. However, the progress notes did not reflect a discussion with DYFS to inquire about the contact with the family and the services they would provide.

There was no contact with the source of the report or collaterals with relatives in NJ. The father contacted WCDSS;

however, he was not asked about his plan to secure medical care for the 2 year old sibling.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/23/2015	13553 - Sibling, Male, 22 Months	13551 - Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Indicated	Yes
	13554 - Sibling, Male, 13 Months	13551 - Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Indicated	
	13554 - Sibling, Male, 13 Months	13551 - Mother, Female, 24 Years	Lack of Medical Care	Indicated	
	13553 - Sibling, Male, 22 Months	13552 - Father, Male, 25 Years	Lack of Medical Care	Indicated	
	13554 - Sibling, Male, 13 Months	13552 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Indicated	
	13554 - Sibling, Male, 13 Months	13552 - Father, Male, 25 Years	Inadequate Guardianship	Indicated	
	13553 - Sibling, Male, 22 Months	13551 - Mother, Female, 24 Years	Inadequate Guardianship	Indicated	
	13554 - Sibling, Male, 13 Months	13552 - Father, Male, 25 Years	Lack of Medical Care	Indicated	
	13553 - Sibling, Male, 22 Months	13551 - Mother, Female, 24 Years	Lack of Medical Care	Indicated	
	13554 - Sibling, Male, 13 Months	13551 - Mother, Female, 24 Years	Inadequate Guardianship	Indicated	
	13553 - Sibling, Male, 22 Months	13552 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Indicated	
	13553 - Sibling, Male, 22 Months	13552 - Father, Male, 25 Years	Inadequate Guardianship	Indicated	

Report Summary:
The report noted the 2 year old sibling was extremely medically fragile and the parents could not provide constant medical supervision due to being “cognitively delayed.” There were concerns about the parents’ hygiene, the siblings not having adequate clothing, the conditions of the home and lack of food. It was noted these conditions existed even though the parents were receiving services. It was not clear whether the family received SSI for the medically fragile sibling or the BM.

The 2 year old sibling was placed in a day program by Blythedale Hospital to attend 5 days a week from 9:00 A.M. to 3:00P.M. The mother was pregnant with her 3rd child.

Determination: Indicated | **Date of Determination:** 12/08/2015

Basis for Determination:
WCDSS substantiated the allegations of IF/C/S, LMC and IG of the siblings by the parents. WCDSS based their determination on the parents failure to fill medical prescriptions for the 2 year old sibling and inability to keep appointments. It was also noted the WCDSS and PPRS observed inconsistent amounts of food and sanitary issues in the home.

The allegations of the report were not properly address individually as it related to each child and subject. For instance, the substantiation for LMC concerning the 13 month old sibling was not specified. There was also no information about the lack of adequate clothes for the sblings.

OCFS Review Results:

The family was involved with housing court for non payment of rent and needed repairs. The parents indicated they were working with DSS to have their benefits transferred to NJ where they expected to relocate. There was poor documentation about the description of the home when visits were made. The WCDSS documented that the home was "reasonably" clean.

Although the BF was hesitant about accepting homemaking services, he later agreed and the family seemed pleased with the services.

WCDSS held a conference with the parents and PPRS. The family was informed that WCDSS would be forwarding a referral to the legal department for COS. The outcome of the referral was not documented.

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

Issue:

Adequacy of Progress Notes

Summary:

The progress notes did not contain detailed information concerning the family's circumstances or the information noted in the SCR narrative.

Legal Reference:

18 NYCRR 428.5

Action:

WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

Collateral contacts relevant to the family's circumstances were not made. There could have been contacts with the landlord, relatives, and services providers who were addressing the pending eviction and obtained more information regarding the family's plan to relocate to another state.

Legal Reference:

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

Action:

WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The RAP was completed without gathering relevant information to respond to the risk elements specific to housing, finances, and support, .

Legal Reference:

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

Action:

WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to Provide Notice of Indication
Summary:
The CONNECTIONS event list does not reflect the Notice of Indication was issued to the parents.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/25/2015	13543 - Sibling, Male, 20 Months	13541 - Mother, Female, 24 Years	Lack of Medical Care	Unfounded	Yes
	13543 - Sibling, Male, 20 Months	13541 - Mother, Female, 24 Years	Malnutrition / Failure to Thrive	Unfounded	
	13543 - Sibling, Male, 20 Months	13542 - Father, Male, 25 Years	Lack of Medical Care	Unfounded	
	13543 - Sibling, Male, 20 Months	13542 - Father, Male, 25 Years	Malnutrition / Failure to Thrive	Unfounded	
	13543 - Sibling, Male, 20 Months	13541 - Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13543 - Sibling, Male, 20 Months	13541 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	
	13543 - Sibling, Male, 20 Months	13541 - Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unfounded	
	13543 - Sibling, Male, 20 Months	13542 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13543 - Sibling, Male, 20 Months	13542 - Father, Male, 25 Years	Inadequate Guardianship	Unfounded	
	13543 - Sibling, Male, 20 Months	13542 - Father, Male, 25 Years	Parents Drug / Alcohol Misuse	Unfounded	
	13544 - Sibling, Male, 11 Months	13542 - Father, Male, 25 Years	Inadequate Guardianship	Unfounded	
	13544 - Sibling, Male, 11 Months	13541 - Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13544 - Sibling, Male, 11 Months	13541 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	
	13544 - Sibling, Male, 11 Months	13541 - Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unfounded	
	13544 - Sibling, Male,	13542 - Father, Male,	Inadequate Food /	Unfounded	

11 Months	25 Years	Clothing / Shelter	
13544 - Sibling, Male, 11 Months	13542 - Father, Male, 25 Years	Parents Drug / Alcohol Misuse	Unfounded

Report Summary:
The report alleged the 20 month old sibling was admitted to the hospital on 8/19/15 due to his medical condition and the parents were refusing to accept intense services at Blythedale Hospital (BH). It was reported the BF was screaming and using foul language when rejecting the service. After meeting with WCDSS, PPRS and a nurse from WMC, the parents agreed with the transfer. The sibling was admitted at BH on 8/27/15.

On 9/7/15, the SCR registered a report alleging the parents smoked marijuana and were rough with the siblings. It was also noted the home was dirty, the furniture where the siblings slept reek of urine and the cats and dog would urinate and defecate in the home.

Determination: Unfounded | **Date of Determination:** 09/22/2015

Basis for Determination:
WCDSS unsubstantiated the allegations of IF/C/S, LMC, M/FTTH, PD/AM, LS and IG of the siblings by the parents. However, WCDSS did not address the allegations for each of the subjects individually for each child.

WCDSS did not thoroughly explore the concerns relatives reported during this investigation, and previous, about the parents' inability to manage the home or care for the siblings. There was no detailed description of the home at every visit and at times it was documented the home was "reasonably" clean. Medical records were reviewed, but the documentation did not include an assessment to reflect whether there were any concerns of LMC for each sibling.

OCFS Review Results:
The reports registered by the SCR were merged. The PA who resided with the family for 3 months indicated the BM was negligent; bottles had sour milk, BM did not change the siblings' diapers or bathed them. The PA said the BM had dropped the 11 month old sibling "on his head" on 3 occasions. The PA stated she left the home because she was tired of cleaning and caring for the siblings. There was no medical follow up concerning the allegations about the BM dropping the 11 month old sibling. The BF said he asked the PA to leave because she was lazy, not paying rent and would get into "fights" with the boyfriend.
The mother was pregnant and was receiving prenatal care.

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

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
WCDSS did not consider information provided by paternal and maternal relatives in this report and others concerning the parents difficulties in caring for the children and maintaining the home clean.
Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Appropriateness of allegation determination
Summary:
WCDSS did not address the allegations individually as it pertained to each child and subject. In addition, relevant information provided by family members was not considered in making the determination.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Predetermination/Assessment of Current Safety and Risk
Summary:
The RAP was completed without gathering relevant information to properly respond to the risk elements regarding housing, finances, resources/ supports, and the parents' clinical condition.
Legal Reference:
18 NYCRR 432.1(aa)
Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/12/2015	13533 - Sibling, Male, 17 Months	13531 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	Yes
	13534 - Sibling, Male, 8 Months	13531 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	
	13534 - Sibling, Male, 8 Months	13535 - Aunt/Uncle, Female, 35 Years	Inadequate Guardianship	Unfounded	
	13533 - Sibling, Male, 17 Months	13536 - Father, Male, 25 Years	Inadequate Guardianship	Unfounded	
	13534 - Sibling, Male, 8 Months	13536 - Father, Male, 25 Years	Inadequate Guardianship	Unfounded	
	13533 - Sibling, Male, 17 Months	13531 - Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13533 - Sibling, Male, 17 Months	13531 - Mother, Female, 24 Years	Lack of Supervision	Unfounded	
	13534 - Sibling, Male, 8 Months	13531 - Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13534 - Sibling, Male, 8 Months	13531 - Mother, Female, 24 Years	Lack of Supervision	Unfounded	
	13533 - Sibling, Male, 17 Months	13536 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13533 - Sibling, Male, 17 Months	13536 - Father, Male, 25 Years	Lack of Supervision	Unfounded	
	13534 - Sibling, Male, 8 Months	13536 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13533 - Sibling, Male,	13531 - Mother, Female,	Inadequate Food /	Unfounded	

17 Months	24 Years	Clothing / Shelter	
13533 - Sibling, Male, 17 Months	13531 - Mother, Female, 24 Years	Lack of Medical Care	Unfounded
13533 - Sibling, Male, 17 Months	13531 - Mother, Female, 24 Years	Lack of Supervision	Unfounded
13534 - Sibling, Male, 8 Months	13531 - Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unfounded
13534 - Sibling, Male, 8 Months	13531 - Mother, Female, 24 Years	Lack of Medical Care	Unfounded
13534 - Sibling, Male, 8 Months	13531 - Mother, Female, 24 Years	Lack of Supervision	Unfounded
13533 - Sibling, Male, 17 Months	13535 - Aunt/Uncle, Female, 35 Years	Inadequate Guardianship	Unfounded
13533 - Sibling, Male, 17 Months	13535 - Aunt/Uncle, Female, 35 Years	Lack of Medical Care	Unfounded
13534 - Sibling, Male, 8 Months	13535 - Aunt/Uncle, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unfounded
13534 - Sibling, Male, 8 Months	13535 - Aunt/Uncle, Female, 35 Years	Lack of Medical Care	Unfounded
13534 - Sibling, Male, 8 Months	13535 - Aunt/Uncle, Female, 35 Years	Lack of Supervision	Unfounded
13533 - Sibling, Male, 17 Months	13536 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded
13533 - Sibling, Male, 17 Months	13536 - Father, Male, 25 Years	Inadequate Guardianship	Unfounded
13533 - Sibling, Male, 17 Months	13536 - Father, Male, 25 Years	Lack of Medical Care	Unfounded
13533 - Sibling, Male, 17 Months	13536 - Father, Male, 25 Years	Lack of Supervision	Unfounded
13534 - Sibling, Male, 8 Months	13536 - Father, Male, 25 Years	Inadequate Guardianship	Unfounded
13534 - Sibling, Male, 8 Months	13536 - Father, Male, 25 Years	Lack of Supervision	Unfounded
13533 - Sibling, Male, 17 Months	13535 - Aunt/Uncle, Female, 35 Years	Inadequate Guardianship	Unfounded
13533 - Sibling, Male, 17 Months	13531 - Mother, Female, 24 Years	Lack of Medical Care	Unfounded
13534 - Sibling, Male, 8 Months	13531 - Mother, Female, 24 Years	Lack of Medical Care	Unfounded
13533 - Sibling, Male, 17 Months	13536 - Father, Male, 25 Years	Lack of Medical Care	Unfounded
13534 - Sibling, Male, 8 Months	13536 - Father, Male, 25 Years	Lack of Medical Care	Unfounded
13534 - Sibling, Male, 8 Months	13536 - Father, Male, 25 Years	Lack of Supervision	Unfounded

13534 - Sibling, Male, 8 Months	13535 - Aunt/Uncle, Female, 35 Years	Inadequate Guardianship	Unfounded
13533 - Sibling, Male, 17 Months	13531 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded
13534 - Sibling, Male, 8 Months	13531 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded
13533 - Sibling, Male, 17 Months	13535 - Aunt/Uncle, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unfounded
13533 - Sibling, Male, 17 Months	13535 - Aunt/Uncle, Female, 35 Years	Lack of Supervision	Unfounded
13534 - Sibling, Male, 8 Months	13536 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded
13534 - Sibling, Male, 8 Months	13536 - Father, Male, 25 Years	Lack of Medical Care	Unfounded

Report Summary:
The report noted the siblings were medically fragile and the parents did not administer prescribed medication or treatment or adequate supervision. It was alleged the siblings were left unsupervised and were kept in dirty diapers for extended periods. It was noted the parents were feeding the 8 month old sibling milk as opposed to formula and this was causing the sibling to vomit after each feeding. The report also noted that a relative took the siblings for medical care after the parents failed to do so and the children were found to have respiratory infections.

WCDSS noted there were concerns about the parents' "cognitive functioning" and they were referred for psychological evaluatio

Determination: Unfounded | **Date of Determination:** 06/22/2015

Basis for Determination:
WCDSS unsubstantiated the allegations of Inadequate Food, Clothing, Shelter; Lack of Medical Care; Lack of Supervision and Inadequate Guardianship of the siblings by the parents and a PA.

WCDSS CW observed the home and the siblings to be clean and the parents demonstrated they had adequate provisions for the siblings. However, WCDSS did not address the allegations individually for each subject to support their decision. The PA who was a subject of this report was used as a collateral for the parents.

The WCDSS did not take into account concerns about the care the parents were providing for the siblings noted by a PA in NJ.

OCFS Review Results:
WCDSS contacted the source who confirmed the narrative in the SCR report. WCDSS questioned why the source registered the report as opposed to asking relevant details concerning the reported information or inquire about the PA residing in the home PA.

The MGPs were no longer residing in the home as they moved to a shelter in Queens and were not contacted. There was no financial assessment of the family's finances or housing status.

WCDSS received information of the siblings medical, EI evaluation and appointments, but did not explore the information provided by the source concerning the parents' failure to seek medical attention for an upper respiratory infection.

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

The source was not asked relevant questions about the narrative in the SCR report. Additionally, the information provided by the source was not considered when making a determination as it was not properly explored.

Legal Reference:

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

Action:

WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The RAP was completed without adequately addressing the issues pertaining to housing, the parents disabilities and finances were relevant in this case.

Legal Reference:

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

Action:

WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Review of CPS History

Summary:

The documentation did not reflect that the ACS investigations were reviewed nor that previous WCDSS investigations were utilized to properly assess the family's needs.

Legal Reference:

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

Action:

WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/19/2015	10226 - Sibling, Male, 15 Months	10223 - Mother, Female, 23 Years	Lack of Medical Care	Indicated	Yes
	10225 - Sibling, Male, 6 Months	10224 - Father, Male, 24 Years	Inadequate Guardianship	Indicated	
	10226 - Sibling, Male, 15 Months	10224 - Father, Male, 24 Years	Lack of Medical Care	Indicated	
	10225 - Sibling, Male, 6 Months	10223 - Mother, Female, 23 Years	Lack of Medical Care	Indicated	
	10225 - Sibling, Male, 6 Months	10224 - Father, Male, 24 Years	Lack of Medical Care	Indicated	

10226 - Sibling, Male, 15 Months	10224 - Father, Male, 24 Years	Inadequate Guardianship	Indicated
10225 - Sibling, Male, 6 Months	10223 - Mother, Female, 23 Years	Inadequate Guardianship	Indicated
10226 - Sibling, Male, 15 Months	10223 - Mother, Female, 23 Years	Inadequate Guardianship	Indicated

Report Summary:
The report noted the parents were not obtaining the needed medical care and assessments for the siblings. In addition, the parents were in receipt of Women, Infant Children (WIC) benefits, but during two home visits there was only one bottle of formula for the 6 month old sibling. The report noted the parents might be "intellectually impaired."

The PGF had moved out of the state with relatives. However, the documentation did not note whether this was specifically due to his health or the pending eviction. Previously, the plan was that he would move with the parents and help put with the rent.

Determination: Indicated | **Date of Determination:** 05/18/2015

Basis for Determination:
WCDSS substantiated the allegations of Inadequate Guardianship and Lack of Medical Care based on the parents not following up on medical appointment for the siblings.

WCDSS noted that the parents followed up with scheduling appointments with the prompting of CPS. There was no exploration if the repeateded reports registered by the SCR concerning the parents

OCFS Review Results:
The WCDSS learned the MGPs had moved in with the parents. The MGPs said they were helping with the care of the siblings, paying "rent" and cleaning of the home (picking up the dog's feces). The MGM noted the BM had been classified as having a learning disability and received special education. The MGM also indicated the BM was a "sickly child" and had a "small head." This information was not thoroughly explored.

The MGM said that at times the BF was "violent." However, she noted there was no "domestic violence issues" between the parents.

WCDSS did not follow up on the family's housing status or complete a financial assessment of the family's income.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
Information provided by the MGM concerning health and developmental delays regarding the mother was not properly explored. In addition, the MGM disclosed the parents difficulty in caring for the children and with the housekeeping in the home to request specific services for them.

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

Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

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

Summary:
The RAP was completed without adequately addressing the issues pertaining to housing, the parents disabilities, and finances were relevant in this case.

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

Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Review of CPS History

Summary:
WCDSS did not document a summary of ACS investigations. In addition, the previous reviews of WCDSS investigations was not utilize to assess the ongoing concerns about the parents' ability to care for the children due to a possible developmental delay.

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

Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/22/2014	10221 - Sibling, Male, 1 Months	10220 - Father, Male, 24 Years	Inadequate Guardianship	Unfounded	Yes
	10221 - Sibling, Male, 1 Months	10219 - Mother, Female, 23 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The report alleged the parents had “mental delays” which interfered with their ability to care for the sibling who was born premature on 9/9/14. The report noted the BM had difficulty holding the newborn sibling; and difficulty changing his diaper. WCDSS observed the parents did not appear to have difficulty in these areas. It was suspected the father appeared to be using illicit drugs.

The WCDSS observed the parents had food in the home and appropriate provisions for the siblings. However, the documentation reflects the parents received some provisions from DSS for the newborn.

Determination: Unfounded | **Date of Determination:** 10/22/2014

Basis for Determination:
The WCDSS unsubstantiated the allegation of Inadequate Guardianship against the parents because the family was observed to properly care for the siblings, there were provisions in the home for the family and it was determined the BF was not using illicit drugs. The BF submitted to a CASAC assessment and a drug screening. The result of the drug screening was negative.

OCFS Review Results:
WCDSS noted the parents were linked to agencies that were providing services to train the parents to properly care for the children and assistance with provisions for the children when needed. This was the third report in 2014 that noted the parents had some "delay” and there was no focus on this issue.

There was no follow up on the family's housing status as in March 2014, it was noted that the family could be evicted at any point. There was also not assessment of the family's finances. It was not reflected in the notes that the WCDSS reviewed the Family's history with ACS.

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

Issue:
Review of CPS History
Summary:
There is no documentation that WCDSS reviewed the family's history with ACS.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Predetermination/Assessment of Current Safety and Risk
Summary:
The RAP was completed without adequately addressing the issues pertaining to housing, the parents disabilities, and finances were relevant in this case.
Legal Reference:
18 NYCRR 432.1(aa)
Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to provide notice of report
Summary:
the CONNECTIONS event list does not reflect a NOE was issued to the PGF.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/05/2014	10218 - Sibling, Male, 7 Months	10216 - Mother, Female, 23 Years	Lack of Medical Care	Indicated	Yes
	10218 - Sibling, Male, 7 Months	10217 - Father, Male, 24 Years	Lack of Medical Care	Indicated	

Report Summary:
On 8/5/14, the SCR registered a report that alleged the 7-month-old sibling was in his stroller when he fell onto a ceramic

floor. The parents were at a clinic and were told to have the sibling examined due to his medical condition, but the parents left the clinic. The parents denied the sibling fell out of the stroller. However, medical staff witnessed the incident. On 8/6/14, the sibling was medically examined and had no injuries from the fall.

The report noted the parents had developmental delays. The mother was pregnant and receiving pre-natal care.

Determination: Indicated | **Date of Determination:** 10/03/2014

Basis for Determination:
The WCDSS substantiated the allegations of Lack of Medical Care of the sibling by the parents because on 8/5/14 they left the clinic with the sibling after being advised to have the child seen medically for a precautionary examination.

OCFS Review Results:
OCFS' review found the WCDSS did not contact ACS to explore past concerns about the parents probable developmental/cognitive delays or their housing status. Also, the mother's history as a child was listed, but there was no summary to reflect it was reviewed.

The WCDSS on several occasions reviewed information of safe sleep with the parents as there were concerns the parents co-slept with the sibling. Medical providers found the parents were properly caring for the sibling.

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

Issue:
Review of CPS History
Summary:
The investigation did not review the family's history with ACS.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to Provide Notice of Indication
Summary:
The CONNECTIONS event list did not reflect a NOI was issued to the parents who were the subjects of the report.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
WCDSS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/03/2014	10215 - Sibling, Male, 3 Months	10213 - Mother, Female, 22 Years	Inadequate Guardianship	Unfounded	No
	10215 - Sibling, Male, 3 Months	10214 - Father, Male, 23 Years	Inadequate Guardianship	Unfounded	

Report Summary:

The BM gave birth prematurely to her first child on a subway platform. The sibling was born with multiple medical issues and remained at Beth Israel Hospital since birth. The medical staff had concerns about the parents' behaviors, hygiene and possible cognitive delays. There was a concern the parents did not have stable housing. At discharge, the sibling was transferred to the Elizabeth Seton Medical Center (ESMC) to continue his medical care.

The PGF, who lived in Yonkers, noted the parents resided with him. The Westchester Department of Social Services (WCDSS) was assigned a secondary role and conducted a home assessment documenting the parents had provisions for the sibling.

Determination: Unfounded	**Date of Determination:** 04/16/2014

Basis for Determination:
ACS unsubstantiated the allegation of IG by the parents noting there was no credible evidence to support the parents were unable to provide a minimum degree of care for the sibling. Also, the social worker (SW) from the ESMC in Yonkers noted the parents were actively caring for the sibling since the child was transferred to ESMC.

Although the PGF allowed the parents to reside with him as of December 2013, the home where they resided was part of an estate that was involved in a court proceeding and there was a possibility the PGF could be evicted.

OCFS Review Results:
The issue of the parents' cognitive delays was not established. ACS and medical staff from both hospitals had different views concerning this matter. ACS learned the BM had a learning disability that did not impact her ability to care for the sibling as indicated by the SW at the ESMC.

ACS attempted to transfer the primary role to WCDSS as the family resided in Yonkers and the sibling was discharged to a medical facility in Westchester. However, the WCDSS did not accept the a primary role and told ACS the family could walk in to their agency to request services.

The ESMC agreed to assess the family's home before the sibling was discharge to the parents.

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

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

The father was listed in two SCR reports as a child; one was indicated. The allegation of these reports were Inadequate Guardianship.

The mother was listed in six SCR reports; five were indicated. The allegations of these reports were Educational Neglect and Inadequate Guardianship.

The father was listed as a subject and parent substitute in a report dated 1/8/10. The allegations of the report were Inadequate Guardianship and Parent Drug/Alcohol Misuse of a 2-year-old child. The report was unfounded. The father submitted to a drug screening and the results were negative for all illicit substances.

Known CPS History Outside of NYS

The Westchester County DSS referred the family to the Division of Youth and Family Services (DYFS) in New Jersey in January 2016. However, the documentation does not reflect that ACS requested DYFS' records.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

The family received preventive services through WCDSS from 10/3/14 through 1/15/16. The WCDSS had case management role. OCFS' review revealed the preventive caseworker (CW) made the required number of casework contacts to meet the program requirement. The two siblings received Early Intervention (EI) screening; the infant was found not eligible for services. The EI screening recommended a special instructor for the one-year-old. The family also received in-home visiting nurse services. The parents accepted homemaking services on 11/3/15, but did not always make themselves available.

According to case documentation, the parents did not maintain a clean and organized apartment and there appeared to be ongoing conflict among extended family members. WDCSS assessed there were high risk concerns due to the parents relatively young age, lack of resources, and inability to respond to crisis relative to the one-year-old sibling's medical needs. Some services ended because the parents were non-compliant. However, the WDCSS did not reassess whether the service plan goals were adequate to address the parents' inability to follow-up with medical appointments and recommendations, secure stable housing or manage resources.

On 12/1/15, the homemaking staff informed the CW the parents planned to relocate to NJ. PPRS ended when the family relocated to NJ.

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

Additional Local District Comments

N/A

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