Child Fatality Report

Report Identification Number: SV-16-052

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

Issue Date: Jun 08, 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 day(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 12/25/2016
Initial Date OCFS Notified: 12/25/2016

Presenting Information

The SCR received a report on 12/25/2016 as well as a subsequent report on 12/26/2016, alleging the 5-day-old SC was breastfed between 2:00 and 3:00am then placed by the SM in bed with the SM and SF. Between 5:40am and 6:25am, the SM and SF awoke to find the SC unresponsive and called 911. The SC was alleged to have no visible injuries and was an otherwise healthy child. The SC was unable to be revived and was pronounced dead at the hospital at 7:09am. A duplicate report was made on 12/27/2016 which alleged the same as the previous reports, but noted there was visible bruising to the SC's face and spots to his body, which can be associated with death by asphyxia. Both parents were named as subjects.

Executive Summary

Westchester County Department of Social Services (WCDSS) received an SCR report on 12/25/2016 regarding the death of the 5-day-old male SC. The report alleged SM and SF were responsible for the death after bed sharing with the SC.

SM told WCDSS, LE, and EMS that she placed the SC in bed with her and SF following a 4:00am feeding. SC slept in a bassinet prior to waking at 4:00am. The SF knew SM awoke to feed the child, but was asleep when SM put him in their bed. SM was IND for her decision to bed share in conjunction with aggravating factors such as the size of the bed, positioning between two adults, and the presence of blankets and pillows. Allegations against SF were Unsub as there was no evidence that he knew of the bed sharing. SM and SF were randomly drug tested shortly following the fatality and both were positive for prescription medications and marijuana. Though parental impairment could not be confirmed at the time of the fatality, WCDSS considered it a risk factor.

The information gathered in the investigation justified the substantiated determination of the allegation of IG against the SM, as well as the unsubstantiated allegation of IG against the SF. Due to the fact that the autopsy report was not received by the time the case closed and no other medical professional could provide some credible evidence about a causal connection, WCDSS could not determine that the factors which placed the SC in impending danger of serious harm directly caused his death. For these reasons, the allegation of DOA/Fatality was unsubstantiated against both parents.

WCDSS received the autopsy report after the case closed and forwarded it to OCFS for this review. The cause of death was noted as, "Sudden unexpected death in 5-day newborn found in bed with adults; undetermined." The ME found no injuries and noted SC appeared well-developed and well-nourished.

In addition to assessing safety within 24 hours, WCDSS made on-going assessments of safety and risk to the 6-year-old SS. WCDSS included the SS's BF, as on-going concerns for the SM existed throughout the investigation. The concerns never rose to the level of requiring a formal safety plan, with the exception of safety planning within the first 72 hours due to unknown circumstances surrounding the death. These concerns included SM and SF's MH, substance use, and unstable housing.

SM, SF, and SS were referred for grief counseling, though the SS was the only one to participate. WCDSS utilized

credentialed alcoholism and substance abuse counselors, victims' assistance and DV services, and referred both parents to MH services. At the time the investigation closed, neither parent had followed through with recommended substance abuse treatment. WCDSS opened a Preventive Services case and were in the process of consulting the legal department to consider filing a neglect petition against the SM regarding the SS. The SF was not included in the neglect petition as he was not the SS's BF, nor was he a person legally responsible for the SS.

An SCR report concerning the SS was made after the fatality investigation. The Multidisciplinary Team investigated alongside LE. Allegations were made against the SS's PA, and WCDSS found no credible evidence to IND the report. The only inaccuracy was that the 7-day safety assessment indicated no safety plan was necessary, noting the SM responded appropriately to the concerns. Due to the seriousness of the concerns, a safety plan was required, and it appeared a safety plan was in fact being implemented based on the mother's actions. At the time of this writing, WCDSS continued to work with SM in the open services case in an effort to mitigate the concerns which warranted long-term involvement.

In response to the citations that came from the review of the fatality investigation and historical cases, WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) WCDSS has taken, or will take, to address all cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
The determination of each allegation as well as the overall determination to indicate the report was appropriate. Additionally, all safety assessments were timely and accurate.

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 level of casework activity was commensurate with the case circumstances, as WCDSS responded to existing and changing concerns in a timely manner throughout the length of the investigation. Sufficient information was gathered to

make a determination and close the case. The circumstances upon closing the case warranted the opening of a Preventive Services case, which was done.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP indicated the SM and SF had developmentally appropriate expectations of all children; however, the 5-day-old infant was placed at significant risk of harm when SC was placed in an unsafe sleep environment. SM and SF's positive toxicology results following the fatality raised the risk because their ability to care for the SC may have been impaired. Two days after the fatality, SM was positive for benzodiazepines, opiates, and cannabinoid and SF was positive for benzodiazepines and cannabinoid, which indicates one or more of the substances could have been in their systems at the time of the fatal incident. Such actions were not developmentally appropriate in consideration of their care for the SC.
Legal Reference:	18 NYCRR 432.2(d)
Action:	WCDSS will take into account all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/25/2016 **Time of Death:** 07:09 AM

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: 06:36 AM
Did EMS to 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? 2 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1

At time of incident supervisor was: Unknown if they were impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	5 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	23 Year(s)
Other Household 2	Father	No Role	Male	29 Year(s)

LDSS Response

WCDSS responded within 24 hours by assessing safety of the SS, making collateral contacts to learn more about the death, and reviewing the family's CPS history. For the 3 reports regarding the fatality, WCDSS contacted each source. WCDSS corresponded with LE to share information, and the record reflects that interviews and home visits were conducted separately. WCDSS made a safety plan with the family when appropriate, and modified the plan when mitigating factors on behalf of the parents and caregivers sufficiently protected the SS.

Accompanied by Victims Assistance Services, WCDSS visited the home of the PGM and PA where the fatality occurred. Neither the SM nor SF resided there; rather, they had visited for the holiday with SC. WCDSS learned from the SM that the SC last woke at 4:00am. She fed the SC breast milk from a bottle and placed the SC on the bed in between her and SF, covered with a thin blanket. SM awoke at 6:30am to find the SC in the same position in which she had placed him to sleep, not breathing. SF called 911 while SM performed CPR. SM indicated she had received safe sleep information upon the birth of the SC at the hospital, and a bassinet was available in the home. WCDSS learned from first responders and LE that the SM provided consistent accounts of the events leading up to the SC's death; namely, the fact that fell asleep with the SC in her bed. The SF reported he last saw the SC in the SM's arms before falling asleep.

WCDSS learned of concern for DV, as SS's PGM reported SM disclosed physical abuse by SF during pregnancy. The SM was eventually questioned separately about DV. Although SM and SF denied any past or present DV, SM was referred to DV services which she declined. WCDSS made service referrals to address additional concerns that were revealed, and when the need arose, a Preventive Services case was opened. The Preventive Services case record noted a legal consultation was in process in an effort to file a neglect petition against the SM regarding SS. The SS's BF was in process of obtaining custody. This matter remained ongoing at the time of this writing. On 3/7/17, a new SCR report was made concerning the SS alleging SA against the SS's PA. The investigation was coordinated with LE, and WCDSS conducted an adequate investigation and subsequently unfounded the report.

The SM, SF, and SS were referred for grief counseling services, though the SS was the only one to utilize the services to date. Timely and accurate safety assessments were completed. The Risk Assessment Profile was thorough, though the

question regarding developmentally appropriate expectations of all children was inaccurate. It was expected that the SC, who was significantly vulnerable given his age and level of development, would be safe in between two sleeping adults surrounded by blankets and pillows; however, those actions were not developmentally appropriate.

WCDSS identified evidence of SM placing the SC in impending danger of serious harm by bed sharing while her ability to care for the child was potentially impaired, in addition to the presence of the aggravating factor of an unsafe sleep environment. No medical professional could provide some credible evidence about a causal connection; therefore, the DOA/Fatality allegation was unfounded.

Official Manner and Cause of Death

Official Manner: Undetermined
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 was conducted jointly between WCDSS and the Yonkers Police Department.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The fatality was reviewed by the Westchester County CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
034121 - Deceased Child, Male, 5 Days	035721 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
034121 - Deceased Child, Male, 5 Days	035722 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated
034121 - Deceased Child, Male, 5 Days	035721 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
034121 - Deceased Child, Male, 5 Days	035722 - Father, Male, 23 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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:

All appropriate collateral contacts were made, with the exception of Emergency Room Personnel/Hospital staff; however, diligent efforts were made to obtain that information. All other casework activities were adequate and appropriate.

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?	☐	☐	☒	☐

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?	☐	☒	☐	☐
Explain as necessary: No removal of the SS was necessary as a result of this fatality report/investigation.				

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Victims Assistance Services							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The SS was referred to mental health services to address the grief surrounding the fatality. WCDSS assisted in expediting his intake appointment given the circumstances.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SF exhibited signs of mental distress following the fatality and MH services were provided. The SM was also referred for MH services. Both parents were also referred for bereavement counseling. Additionally, WCDSS provided services to the parents unrelated to the fatality, such as DV/Victim Advocacy Services and substance abuse.

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
☐ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:

☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

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)
02/29/2016	13507 - Sibling, Male, 6 Years	13503 - Mother, Female, 25 Years	Lack of Supervision	Unfounded	Yes
	13507 - Sibling, Male, 6 Years	13503 - Mother, Female, 25 Years	Excessive Corporal Punishment	Unfounded	
	13507 - Sibling, Male, 6 Years	13503 - Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unfounded	
	13507 - Sibling, Male, 6 Years	13503 - Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	

Report Summary:
SCR report alleged SM used excessive physical discipline towards SS by hitting his face, head, and body. SM abused prescription drugs daily to the point of impairment while caring for SS. SM left the pills accessible to the child and on one occasion, SS was found with one of the pills in his mouth. PGM and SS's BF had unknown roles. Allegations were XCP, PD/AM, LS, and IG against SM regarding SS.

Determination: Unfounded | **Date of Determination:** 04/11/2016

Basis for Determination:
PGM and SM denied the reported concerns. When SS was interviewed, he made no concerning disclosures nor was he found to have any marks, bruises, or injuries. SM admitted to taking prescribed medication for a mental health diagnosis, but denied leaving it accessible to the child. At home visits, WCDSS did not find that any medications were accessible to the SS. SM was drug tested and found to be positive for marijuana. SM was linked to community-based services such as drug treatment, mental health, and a shelter for permanent housing.

OCFS Review Results:
WCDSS appropriately addressed the reported concerns with all relevant family members, spoke with collaterals, and made referrals which were helpful to the family. The RAP inaccurately assessed risk in that SS's BF was not identified as a secondary caretaker. There were instances of insufficient documentation and the source was never contacted.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:

The Risk Assessment Profile inaccurately assessed risk in that SS's BF was not identified as a secondary caretaker. At the time the RAP was completed, CW had identified that SS's BF cared for the child on weekends.

Legal Reference:

18 NYCRR 432.2(d)

Action:

WCDSS will include all appropriate caretakers on the Risk Assessment Profile so as to accurately reflect risk to families.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

WCDSS failed to contact the source of the SCR report.

Legal Reference:

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

Action:

WCDSS will contact (or make diligent efforts to contact) the source of all SCR reports so as to verify adequacy of report and possibly glean additional information.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/12/2015	13502 - Sibling, Male, 5 Years	13501 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	Yes

Report Summary:

SCR report alleged SM physically assaulted an adult female in the presence of SS. The incident resulted in SM's arrest. SM had threatened to harm the woman in the past. The role of SS's BF was unknown. The allegation was IG against SM regarding SS.

Determination: Unfounded | **Date of Determination:** 07/09/2015

Basis for Determination:

WCDSS found that SM approached the BF of the SS and confronted him about child support. The argument escalated to a physical altercation between SM and BF's girlfriend and the dispute was broken up by men in the community. This occurred in the presence of the child. SM was arrested and an order of protection was issued against SM. BF fled the scene prior to police arrival and SM called SS's PGF to get SS when she was arrested. WCDSS determined that because the child was not injured or harmed as a result of the incident, there was no basis to substantiate the allegation of IG.

OCFS Review Results:

WCDSS diligently gathered information from the family and collaterals. The 7-Day safety and risk assessments were appropriate; however, the investigation conclusion safety assessment was inaccurate as the safety factor regarding a caretaker's recent history of violence was still relevant. The overall determination should have been IND. Sufficient information was gathered to determine that the SS was in imminent danger of harm when SM engaged in physical violence with BF's girlfriend in SS's presence. She also placed SS at risk by approaching BF, knowing there was an active stay-away order of protection between her and BF due to DV (physical violence), and continued to confront BF despite him continually telling her to leave him alone.

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

Issue:

Appropriateness of allegation determination

Summary:

The basis for unsubstantiating the allegation of IG was that SS was not injured or harmed as a result of the incident; however, the definition of IG includes imminent danger of harm. The child was found to have been in imminent danger

of such harm, given that the physical altercation occurred in his presence and a stay-away order of protection between adults was violated in his presence as well.

Legal Reference:

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

Action:

WCDSS will refer to the CPS Program Manual and/or consult the Spring Valley Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definitions.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The investigation conclusion safety assessment was inaccurate as the safety factor regarding a caretaker's recent history of violence was still relevant. Both parents had a recent history of being violent/out of control. CW indicated that no safety factors were present.

Legal Reference:

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

Action:

WCDSS will complete accurate assessments of safety and document accordingly in all safety assessments.

[redacted]

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

There was one UNF report dated 4/18/2011 which alleged IG and L/B/W against SM regarding SS.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes

From: Unknown	To: Unknown

Explain:
In July of 2014, an order of protection was issued against the SS's BF for the SM. This was in regards to incident in which the BF choked the SM. The record indicates it was a stay-away order of protection. It is unclear as to the length that this order was to remain in place; however, in the 2016 investigation there was note that an order of protection remained in place that the BF was to refrain from violence in the presence of SM and the SS.

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