Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-17-012

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

Issue Date: Oct 16, 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	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old

Case Information

Report Type: Child Deceased
Age: 8 month(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 04/24/2017
Initial Date OCFS Notified: 04/24/2017

Presenting Information

On the evening of 4/24/2017, The Maternal Aunt (MA) put the 8-month-old SC (Twin A) down for a nap at in his crib in the family home. The MA later found the SC unresponsive. The MA took the SC with the Maternal Uncle (MU) to the hospital in a private car at approximately 7:00 PM. It was there that the baby was later pronounced dead. The SC had no known medical conditions that would cause this. The SF and the SM were listed on this report as subjects, since there was no explanation for the SC's death, it was deemed suspicious. The role of the SSs and (Twin B) were listed as unknown roles.

Executive Summary

An SCR report was received on 4/24/2017, and a joint investigation was conducted by the LE and Westchester County Department of Social Services (WCDSS). WCDSS initiated an immediate investigation that included contact with the source and all other required contacts. SCR and criminal history checks were completed and reviewed. This report was subsequent to an open/pending CPS investigation that began on 3/18/2017, and was still under investigation at the time of the reported fatality.

In the first 24 hours of the investigation, WCDSS adequately assessed the safety of the SS (age 5) the SS (age 4), Twin B, Cousin (age 9), Cousin (age 6), Cousin (age 3) and Cousin (18-month-old). WCDSS implemented a safety plan. All the family members live in the same apartment building and provide each other with support. The MGF and his wife agreed to and were watching all the children as part of the safety plan. The SM and the MA agreed to this plan pending further investigation. The SF had no access to the SM or the chn at the time of the safety plan, due to a stay away order of protection from the 3/18/2017 INV for assaulting the SM. That INV revealed that SSs and the Twin did not witness the reported incident.

Based on interviews and information gathered through the course of the investigation, it was learned that the SM had attempted to harm herself while pregnant with the twins. WCDSS, given SM history and the current loss of the SC, appropriately requested the SM complete a mental health evaluation. WCDSS also offered the family referrals for grief counseling and requested drug screening as part of their protocol. The SM and the SF agreed to be drug tested. The SM and the SF tested negative for any drug use.

WCDSS also learned that the SC was born about 5 weeks premature. The SC spent two weeks in the hospital prior to going home with the SM. The SC had breathing issues that were resolved in the first 24 hours after his birth, as reported to WCDSS by the pediatrician. The SC was under weight and his weight was monitored by the pediatrician.

WCDSS learned from the MA that on the evening of the reported fatality the SM had gone out and she was caring for the SC and the SSs. It was reported that the MA observed the SC sleeping on his back in the crib at 6:00 PM. The MA checked on the SC at 6:30 and the SC was still sleeping. At 6:50 the MA went in again to check on the SC and found the SC unresponsive and not breathing. The MA ran to the MGF's apartment in the same building with the SC. The MU and the MA went in a car to the hospital with the SC. The SC was pronounced dead at 7:20 PM. The MA explained she did not call 911 as she panicked and they decided it would be faster to transport the SC to the hospital.

An autopsy was performed on 4/24/17 by the ME. The autopsy results listed the cause of death as, undetermined and the manner of death as, sudden unexplained death of an 8 month old prematurely born infant. WCDSS appropriately Unsub

the allegation of DOA/Fatality, IG and LMC reegarding the SM for the SC and IG and LMC for Twin B. WCDSS Unsub the allegation of DOA/fatality and IG against the MA and the SF for the SC. The SF and the SM were not home at the time of the reported fatality. The SC was in the care of the MA. The MA regularly took care of the SC and the SSs and there were no reported concerns about the care that the MA provided to the chn. The medical reports all stated there was no evidence of abuse/maltreatment. Based on interviews, medical records and all other appropriate collateral contacts there was no evidence to support the allegations against the MA, SM or the SF. This investigation was UNF and closed with referrals to community based services.

From the time of the receipt of this report WCDSS had frequent contact with the all family members. WCDSS continued to gather information relevant to the ongoing investigation and assisted the family as needed with community-based services prior to the case closing.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
WCDSS conducted a thorough and complete investigation and offered appropriate services was needed. Made frequent home visits and adequately assessed the safety of all the chn listed in the case.

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:
From the time of the receipt of the report WCDSS had frequent contact with the SF, the SM, MA, the SS and the cousins in their homes. WCDSS continued to gather information relevant to the investigation. WCDSS conducted adequate safety and risk assessments.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/24/2017 **Time of Death:** 07:20 PM

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: 07:00 PM
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? 20 Minutes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	8 Month(s)
Other Household 1	Aunt/Uncle	No Role	Male	27 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Female	28 Year(s)
Other Household 1	Other Adult - Family member	No Role	Male	33 Year(s)
Other Household 1	Other Adult - Family member	No Role	Female	23 Year(s)

Other Household 1	Other Child - cousin	No Role	Male	3 Year(s)
Other Household 1	Other Child - cousin	No Role	Female	10 Year(s)
Other Household 1	Other Child - cousin	No Role	Male	6 Year(s)
Other Household 1	Other Child - counsin	No Role	Male	18 Month(s)
Other Household 1	Other Child - cousin	No Role	Female	0 Month(s)

LDSS Response

On 4/24/17, WCDSS received an SCR report alleging DOA/Fatality, LMC and IG against the SM for the SC, IG and LMC for Twin B. The report also had allegations of DOA/Fatality and IG against the SF and the MA for the SC. A joint investigation was conducted by WCDSS and LE. Through investigation and interviews it was learned the SF and the SM were not in the home at the time of the reported fatality. The MA was caring for the SC and the SSs in their home. The MA reported that the evening of 4/24/2017 the SM had placed the SC in the crib before leaving the home for a driving lesson. The MA observed the SC sleeping and the SC was breathing with a soft wheezing sound. The MA again checked on the SC at 6:30 PM and stated the SC was still in lying on his back in the crib in the same position with his head and body tilted to the right. The SC was still breathing with a soft wheezing sound. The MA checked on the SC again at 6:50 PM and found him unresponsive and not breathing. The SC was now observed to be lying on his back in the farthest corner of the crib facing away from the wall. The SC was not covered with any blankets and was just wearing his pajamas. The MA stated the room was warm and comfortable. The MA ran to the MGF's apartment and the MU transported her to the hospital with the baby. One of the other family members had called 911. However, they thought it would be quicker to transport the SC to the hospital. The SC was pronounced dead at 7:20 PM.

Upon further investigation, it was learned the SF was not in the home at the time of the reported fatality. There was a full stay away order in place because the SF was arrested for assaulting the SM on 3/18/2017 and there was an open INV with WCDSS. The SF followed the terms of the court order and was fully cooperating with WCDSS. The investigation also revealed that the SM was not home at the time of the reported fatality. However, the SM had tried to harm herself when she was pregnant with the SC and Twin B. WCDSS appropriately requested that the SM undergo a mental health evaluation based on the above information and the recent passing of Twin A.

A SCR history check was completed and reviewed. A criminal history check was completed. WCDSS referred and offered numerous services to all family members, including but not limited to, MH evaluations, bereavement counseling, drug testing and early intervention. The MA had a baby during the INV and WCDSS appropriately assessed for the safety of the new born cousin as well. WCSDSS provided brochures and educated all family members on safe sleep practices.

During the investigation WCDSS interviewed the source, all family members and SSs were interviewed and observed. The SSs were examined at CAC for medical exams and were found to be in good health. All appropriate collateral contacts were made including pediatrician, treatment professionals and schools. The WCDSS did an assessment of both the MA and the SF and SM home and found there were no other safety concerns. The autopsy results were the cause of death was undetermined and the manner of death was sudden unexplained death of an 8 month old prematurely born infant.

WCDSS appropriately Unsub the allegations of DOA/Fatality, LMC and IG regarding the SM for the SC and Twin B. The allegations of Unsub DOA/Fatality and IG against the MA and the SF for the SC. There was no credible evidence to support the allegations based on all the information gathered during the investigation. The SF complied with the court and the full stay order was modified to a refrain from order. The order stated the SF needed to refrain from any harassment or physical/verbal abuse of the SM. The order would be in effect until 4/21/2019. The SF was allowed to return to the home. The whole family fully cooperated with WCDSS and provided each other with support as needed. The case was UNF and closed and family was referred to community based services.

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041021 - Deceased Child, Male, 8 Mons	041026 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
041021 - Deceased Child, Male, 8 Mons	041025 - Father, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
041021 - Deceased Child, Male, 8 Mons	041026 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
041021 - Deceased Child, Male, 8 Mons	041026 - Mother, Female, 26 Year(s)	Lack of Medical Care	Unsubstantiated
041021 - Deceased Child, Male, 8 Mons	041025 - Father, Male, 29 Year(s)	DOA / Fatality	Unsubstantiated
041021 - Deceased Child, Male, 8 Mons	041029 - Aunt/Uncle, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
041021 - Deceased Child, Male, 8 Mons	041029 - Aunt/Uncle, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
041022 - Sibling, Female, 8 Month(s)	041026 - Mother, Female, 26 Year(s)	Lack of Medical Care	Unsubstantiated
041022 - Sibling, Female, 8 Month(s)	041026 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐

Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: None of the SS were removed.				

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
WCDSS referred the chn and family to bereavement services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WCDSS referred the family to bereavement services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ 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)
03/18/2017	Sibling, Female, 4 Years	Father, Male, 29 Years	Inadequate Guardianship	Unfounded	No
	Deceased Child, Male, 8 Months	Father, Male, 29 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 8 Months	Father, Male, 29 Years	Inadequate Guardianship	Unfounded	

	Sibling, Male, 5 Years	Father, Male, 29 Years	Inadequate Guardianship	Unfounded

Report Summary:
On 3/18/2017, the SCR a received a report alleging IG against the SF for the SSs and the SC. The report alleged the SF arrived home and was intoxicated. The SF and the SM were arguing because the SF had been drinking. The SF struck the SM in the face and physically abused her in the presence the chn. The SM's role was unknown.

Determination: Unfounded **Date of Determination:** 05/17/2017

Basis for Determination:
The SCR report received on 3/18/2017 was UNF and the allegation of IG against the SF was Unsub. The SF was arrested and there was a full stay OOP. However, the police report showed that none of the chn witnessed the incident or were injured. Family members were interviewed and referred to services. There were no other DIR's with LE.The SM was not afraid of the SF. The SF complied with the order and engaged in services. The SF subsequently tested negative for any substances. SF plead guilty to disorderly conduct and paid a fine. The OOP was modified to a refrain from order and the SF was allowed back in the home. The case was closed and the family was referred to community based services.

OCFS Review Results:
OCFS found that WCDSS made the appropriate determination based on the information gathered during the investigation.

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)
09/06/2016	Other Child - cousin, Female, 9 Years	Aunt/Uncle, Female, 28 Years	Inadequate Guardianship	Far-Closed	No
	Other Child - cousin, Female, 9 Years	Aunt/Uncle, Male, 33 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
On 9/6/2016, the SCR a received a report alleging that the Aunt and Uncle were verbally and physically aggressive with the now 9-year-old cousin of the SC. The cousin was heard screaming as a result of being hit. This happens a few times a week and had been ongoing for the past few months. It is unknown if the cousin had any injuries. The role of the two other chn was unknown.

WCDSS became involved with the family on 9/6/2016 following concerns reported to the SCR regarding IG for their 9-year-old daughter. The family agreed to the FAR track and accepted parenting services to assist them in appropriate techniques for discipline for their chn.

OCFS Review Results:
OCFS found that WCDSS made the appropriate determination based on the information gathered during the investigation.

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)
03/24/2016	Sibling, Male, 5 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	No
	Sibling, Female, 4 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	

Report Summary:
On 3/19/2016, the SM was feeling overwhelmed and took an overdose of iron pills to harm herself. The SS now age 3

and age 4 were in the home at the time. The SM was taken to the hospital for treatment. There was concern about the SM's mental health status. The role of the SF and the Aunt were unknown.	
Determination: Unfounded	**Date of Determination:** 05/23/2016
Basis for Determination: There was no credible evidence to support the allegation of IG against the SM for the SS. At the time the SM took the iron pills she was not at home. The Aunt for the SS were being cared for at the time of the reported incident and they were not impacted or harmed in any way. The SM was referred for counseling and was in counseling when the case closed. The case was UNF and closed. Referred to community based services.	
OCFS Review Results: OCFS found that WCDSS made the appropriate determination based on the information gathered during the investigation.	
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No	

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

11/29/2012-Allegations of IG and IF/C/S against the Aunt, Uncle, GP and SM were Unsub for the Cousins. The INV was UNF.

Known CPS History Outside of NYS

There is no known 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.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement 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: 04/17/2017	**To:** 04/21/2017
Explain: There was a full stay away order through criminal court with the SF listed as the defendant. The order was issued on 3/18/2017 against the SF for assaulting the SM on 3/18/2017. The order was modified after the SF plead guilty to disorderly conduct and had complied with recommended evaluation and services. The order was changed to a refrain from for two years on 4/21/2017.	

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