Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-20-006

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

Issue Date: Aug 31, 2020

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 6 day(s)
Jurisdiction: Washington
Gender: Female
Date of Death: 01/24/2020
Initial Date OCFS Notified: 03/13/2020

Presenting Information

On 3/13/2020, Washington County Department of Social Services (WCDSS) notified OCFS of the death of the 6-day-old female subject child who passed away on 1/24/2020 by completing a 7065-Agency Reporting Form. The child was born prematurely on 1/18/2020 and did not leave the hospital during her lifetime.

Executive Summary

This fatality report concerns the death of the 6-day-old female subject child who died on 1/24/2020. The child died during an open CPS investigation regarding concerns the mother used drugs and had explosive behaviors. The report alleged the parents had verbal disputes in the presence of the children and the mother broke a television. The child had four siblings, ages 7, 8 and two 9-year-old siblings. The children were assessed to be safe in the care of their parents.

On 2/19/2020, WCDSS learned of the child's death during a routine home visit with the family. A 7065-Agency Reporting Form was completed and sent to OCFS on 3/13/2020.

Although the medical records were requested from the hospital, the records had not been received at the time this report was written. It remained unknown if an autopsy was completed. Additionally, the cause and manner of death remained unknown.

The parents were offered services in response to the fatality; however, they declined counseling through the Department as they were engaged in counseling for unrelated reasons. The father declined services on behalf of the siblings and the parents answered any questions the children had regarding the death.

PIP Requirement
WCDSS and the ACS will submit PIPs to their Regional Offices within 30 days or 45 days of the receipt of this report, respective to their jurisdiction regulations. The PIP will identify action(s) the jurisdictions took, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, WCDSS and ACS will review the plans and revise as needed to address ongoing concern.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A

- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
Casework activity was commensurate with case circumstances.

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 decision to close the case was appropriate.

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: 01/24/2020 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Albany
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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? Unable to determine

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	No Role	Female	6 Day(s)
Deceased Child's Household	Father	No Role	Male	36 Year(s)

Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Other Household 1	Other Adult - Father of SS	No Role	Male	29 Year(s)
Other Household 2	Other Adult - Mother to siblings	No Role	Female	36 Year(s)
Other Household 2	Other Adult - Mother to siblings	No Role	Female	36 Year(s)

LDSS Response

On 2/19/2020, the mother informed Washington County Department of Social Services (WCDSS) of the death during a routine home visit due to the open CPS investigation. On 3/13/2020, WCDSS notified OCFS of the death by completing the 7065-Agency Reporting Form. WCDSS reported the child was born at 37 weeks gestation and had medical complications. The medical complications included underdeveloped lungs and fluid on the lungs. WCDSS reported the child died as a result of her medical complications. Information was requested from the hospital; however, WCDSS did not receive the requested records.

During the open investigation, the safety of the siblings was assessed. Several home visits were conducted, and the children were assessed to be safe in the care of their parents. The children did not provide information relating to the child or the child's death.

The parents reported the child was born at the hospital with medical complications and spent her life in the hospital. The child passed away at the hospital on 1/24/2020.

The family was offered counseling services in response to the fatality; however, the parents declined the referral. The parents were engaged in counseling prior to the child's death and planned to continue services through their provider. The parents declined services for the siblings. The case was closed on 4/16/2020.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Washington County does not have an OCFS-approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐

When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☐	☐	☒
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The child was born and passed away in the hospital. The child did not live outside of the hospital.

Fatality Safety Assessment Activities

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

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐
Explain: The safety of the siblings was appropriately assessed following the death of the child.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☐	☒	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐

Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
The parents were offered counseling services; however, the record did not reflect if additional services were offered in response to the fatality.

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:
No children were removed as a result of the death.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
WCDSS offered counseling services; however, the parents were already engaged in counseling due to challenges unrelated to the fatality.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
The parents reported addressing the death with the children and declined a counseling referral for the siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were engaged in counseling regarding relationship challenges prior to the child's death.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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? Yes

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)	Allegation Outcome	Compliance Issue(s)
11/14/2019	Sibling, Female, 8 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Female, 8 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Years	Father, Male, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 8 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 6 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 6 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 9 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 6 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged mother abused Suboxone to the point of impairment while being the sole caretaker to the siblings. When impaired, the mother was explosive and physically aggressive, and unable to care for the children adequately. On at least one occasion, while impaired, the parents argued and the fight became physical when the mother smashed the television in the presence of the siblings. It was unknown if any of the children sustained physical injury as a result. The father was aware of the mother's behaviors but failed to adequately intervene.

Report Determination: Unfounded | **Date of Determination:** 04/16/2020

Basis for Determination:
Although the investigation revealed there were altercations between the mother and the mother of the siblings; the record did not reflect a negative impact on the children. Collateral contacts were made and there were no concerns the mother abused drugs. Although there were concerns the siblings were sometimes unbathed while in the care of their mother, the record did not reflect a basis for determining the allegation of Inadequate Food, Clothing and Shelter. The allegations of Parent Drug/Alcohol Misuse and Inadequate Guardianship were unsubstantiated as the mother tested negative for illicit substances.

OCFS Review Results:
The investigation was initiated timely, the source of the report was contacted, and a CPS history check was documented. The 7-day Safety Assessment was not completed timely. Notice of Existence letters were provided to the adults timely. The safety of the children was adequately assessed throughout the investigation. The Risk Assessment Profile was completed inaccurately.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The Risk Assessment Profile was completed inaccurately as it did not reflect the caregiver's history of domestic violence involving another adult. The case record noted the mother and mother to the siblings were given appearance tickets for fighting in the presence of the children.

Legal Reference:
18 NYCRR 432.2(d)

Action:
WCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Timely/Adequate Seven Day Assessment

Summary:
Although the 7-day Safety Assessment accurately reflected case circumstances, it was not completed until 11/26/19.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
WCDSS will complete all Safety Assessments in the accordance with regulations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/01/2019	Sibling, Female, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 7 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged on 10/1/19, an argument ensued between the parents while they were getting the siblings ready for school. The argument escalated and the mother threw a hairbrush which broke the television. She then punched the television. The mother pushed the 8-year-old sibling and threw the hairbrush which subsequently hit the 5-year-old sibling in the face. The mother struck the father in the presence of the children. There was a history of the mother being physically and verbally aggressive in the home.

Report Determination: Unfounded | **Date of Determination:** 11/14/2019

Basis for Determination:
WCDSS unsubstantiated the allegations noting the family denied the allegation of physical violence. Although the investigation revealed the mother did break the television by throwing a hairbrush at it, the investigation did not identify the children experienced harm due to the arguments between the parents.

OCFS Review Results:
WCDSS initiated the investigation timely by speaking with the source. The Safety Assessments and Risk Assessment Profile were completed with accuracy. Notice of Existence letters were not provided to all adults listed on the report.

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

Issue:
Failure to provide notice of report

Summary:
Although written notice was provided to the subject child's parents and the mother of the siblings, the record did not reflect written notice was provided to the father of the 9-year-old sibling.

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/19/2019	Sibling, Female, 9 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 9 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 6 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged the mother was on parole for drugs and lost custody of her children. On 6/18/19, the mother lost control and physically assaulted the father in the presence of the siblings, ages 6, 7 and 9 years. The mother beat the father while he and the children begged and screamed for the mother to stop. The mother punched a vehicle and smashed the vehicle's window with a sledgehammer. The mother acted like she was under the influence of drugs. The role of the father was unknown.

Report Determination: Unfounded | **Date of Determination:** 10/22/2019

Basis for Determination:
The allegations of Inadequate Guardianship and Parent Drug/Alcohol Misuse were unsubstantiated against the mother. WCDSS documented the siblings said the parents fight regularly and the mother punched the father's vehicle and threatened to hit the vehicle with a sledgehammer. The children reported being nervous when the parents fought. The parents denied the allegations and said the children were not present when they fought.

OCFS Review Results:
The case was initiated timely and a CPS history check was documented. Home visits were made to the case address, and attempts were made to contact the mother of the siblings. The Safety Assessments accurately reflected the case record.

The 9-year-old sibling moved into the home and was not added to the case. Her father was not contacted regarding the SCR report. The parents were interviewed together regarding domestic violence concerns. The case was inappropriately determined. Progress notes were not entered contemporaneously with their event dates. The Risk Assessment Profile was completed accurately.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Progress notes were entered nearly four months after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
Although the interviews with the children were thorough and appropriate, the parents' interviews were inadequate. The record did not reflect the parents were interviewed separately regarding the concerns for domestic violence which often occurred in the presence of the children. The record did not reflect the 9-year-old sibling's father was contacted with regard to the SCR report.
Legal Reference:
432.1 (o)
Action:
WCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Appropriateness of allegation determination
Summary:
The case was determined inappropriately. The case record reflected the children reported witnessing the parents fight verbally and physically. The children said they did not feel completely safe in the home. The children reported crying when the parents fought and cried when they were interviewed. The children also reported witnessing the parents break the television.
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 with the Albany Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Issue:
Failure to obtain the name, age, and condition of other children in the home
Summary:
Although interviewed, the 9-year-old sibling moved into the house during the investigation and she was not added to the case.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(e)
Action:
A full child protective investigation must include obtaining the name, age and condition of children in the home. For children who are identified as living in the home, WCDSS must add the child to the case.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/02/2018	Sibling, Female, 7 Years	Other Adult - BF of SS, Male, 28 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Female, 7 Years	Other Adult - BF of SS PS, Female, 35 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report alleged the 7-year-old sibling resided with the mother and had visitation with her father and step-parent. On several occasions the step-parent became angry with the sibling and kicked her out of the home and failed to make adequate arrangements for her care. The sibling's father was aware but failed to intervene. The sibling feared the step-parent. The role of the mother was unknown.

OCFS Review Results:
The case was appropriately tracked FAR and initiated timely. Home visits were made, and the interviews were appropriate. The 7-day Safety Assessment was completed timely and accurately. The record did not reflect the maternal aunt's partner, a home member, was seen or interviewed. Documentation within the FLAG was appropriate. Letters of notification and FAR closure were provided to all adults. Progress notes were not entered contemporaneously with their event dates.

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

Issue:
FAR-Failure to Interview Other Persons
Summary:
Although the interviews that were conducted were thorough and well documented, the record did not reflect an unrelated home member was seen or interviewed regarding the FAR case.
Legal Reference:
18 NYCRR 432.13 (d)(1)(ii) & (iii)
Action:
Family assessment response workers must work in partnership with the families participating in a family assessment response. Workers should be transparent with families regarding all actions that they take regarding the case. To the extent feasible, child protective service workers should include all family members in discussions, including children who are old enough to express opinions, as well

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Some progress notes were not entered contemporaneously with their event dates. Some progress notes were not entered until three months after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/02/2017	Other Child - OC3, Female, 7 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 7 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged on 9/13/17, the mother struck an unrelated home member's vehicle with a baseball bat. The mother then went into the home and brought the 7-year-old unrelated child and 6-year-old sibling outside and gave them the baseball bat, allowing them to strike the vehicle. Felony damage was caused to the vehicle as a result. The roles of the unrelated home member and maternal grandmother were unknown.

Report Determination: Unfounded | **Date of Determination:** 12/12/2017

Basis for Determination:
The allegations were denied by the mother and children; however, the mother was arrested for and placed on house arrest after being charged with property damage. Additionally, a collateral contact said she witnessed the mother and children hitting the vehicle. Although it was undetermined if the event occurred, the allegations were unsubstantiated as there was no known negative impact on the children.

OCFS Review Results:
The investigation was initiated timely and the source was contacted. A CPS history check was documented and Safety Assessments were completed timely. Although some adults and all children were interviewed, the record did not reflect the sibling's father or the alleged unrelated home member were contacted regarding the report. Furthermore, the record did not reflect the father was provided with written notice of the SCR report.

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

Issue:
Failure to provide notice of report
Summary:
Although the adults on the report were provided with written notice timely, the record did not reflect the sibling's father was notified of the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
WCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
Although some home members and grandmother were interviewed regarding the report, the record did not reflect an unrelated home member was contacted. Additionally, the record did not reflect attempts were made to contact the father of the sibling regarding the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including home members and absent parents. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/20/2017	Sibling, Female, 6 Years	Mother, Female, 28 Years	Educational Neglect	Unsubstantiated	Yes

Report Summary:
An SCR report received by ACS alleged the 9-year-old sibling missed an excessive amount of school and was falling behind academically as a result. The mother was aware of the sibling's academic situation but did not take the necessary steps to make sure the child attended school. The investigation was transferred to Washington County.

Report Determination: Unfounded **Date of Determination:** 05/10/2017

Basis for Determination:
The SCR report was initially received by ACS jurisdiction and was transferred to WCDSS. During the investigation, the mother made attempts to obtain appropriate housing for the child; however, the family remained in a shelter. The mother was compliant with CPS but was denied assisted housing. The mother and sibling moved to Washington County during the investigation. The investigation conclusion narrative stated the lack of housing was a barrier for the mother, yet due to her efforts, the allegations were unsubstantiated.

OCFS Review Results:
The investigation was initiated timely and the source was contacted. The 7-day Safety Assessment was completed timely. The mother was not provided with written notice. The record did not reflect attempts were made to contact the sibling's father. Several home visits were made, and concerns were addressed. The case was closed with a very high-risk rating and the record did not reflect Preventive Services were offered.

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

Issue:
Confidentiality of CPS Information
Summary:
The record reflected a breech of confidentiality as the record noted calls were made to the maternal grandmother and a family friend in order to locate the family. The record reflects the caseworker informed the collaterals of the SCR report and its concerns.
Legal Reference:
SSL 422(4) and (5)
Action:
The Administration for Children's Services must not reveal information from the report to collateral sources.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
Although Washington County provided the father with written notice of the SCR report, Washington County did not document attempts to contact the sibling's father regarding the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
Washington County Department of Social Services will contact or make diligent efforts to contact relevant collateral sources who may have information relevant to the investigation, including absent parents.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The case record reflected the mother and sibling moved to Warren County prior to case closure. The record did not reflect the new home was assessed for safety and risk prior to case closure. The case was closed with a very high risk rating and the record did not reflect services were offered in Washington County or Warren County prior to case closure.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
Washington County will prioritize making an adequate assessment of safety and risk regarding the children listed on a case and continue to assess the safety and risk throughout the investigation. The safety and risk will be assessed prior to case closure, including in the event the family moves out of jurisdiction.

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

Between 10/8/10 and 2/2/17, the mother was involved in 14 SCR reports. The mother had an extensive history of drug abuse which resulted in her being substantiated for Inadequate Guardianship, and Parent Drug/Alcohol Misuse on multiple occasions. Additionally, the mother at times was unable to provide stable housing for the 9-year old sibling. There were allegations made against the mother regarding Burns and Lacerations/Bruises/Welts on the 9-year-old sibling as well as concerns for Lack of Supervision, which were unsubstantiated. Some of the investigations include the same allegations against the father of the 9-year-old sibling. During periods the mother was unable to provide housing for the child, allegations of Lack of Medical Care and Educational Neglect were unsubstantiated several times.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

Preventive Services History

A Preventive Services case was opened on 10/19/15 regarding the mother and 9-year-old sibling. The family was referred to Services by a CPS worker in Queens. There were concerns the mother needed drug addiction treatment and parenting classes to assist her in discipling techniques. The case was closed on 11/19/15. The family moved out of the jurisdiction and did not wish to continue Services in another jurisdiction.

The mother and 9-year-old sibling were involved in an FSS from 12/9/16- 3/31/17. An ACS worker made a referral after learning of concerns the mother had untreated mental heath challenges, drug addiction history and lacked finances and a support system to obtain appropriate housing. Additionally, the 9-year-old sibling was not enrolled in school and needed a mental health evaluation. Throughout the FSS, the mother was compliant, but struggled to obtain consistent housing. The FSS was closed as the family moved out of jurisdiction. The record reflected no goals were completed; however, no other jurisdiction was assigned, and the Preventive case was closed.

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

Washington County currently requires casework staff to ensure a family's demographic information is kept up to date through use of a Family Resources worksheet. Information is to be gathered and updated at each meeting with family members. Information is then to be uploaded into CNX as the first case note in every case and then as an amended note as new information is gained. Unlike with WMS, CNX does not allow for the entry of unborn children into household composition. The inability to do so in this particular case highlights the need for Washington County to devise a system to ensure there is solid follow-up in a timely fashion with families around unborn baby's due dates, particularly with riskier pregnancies.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☒Yes ☐No

Action:	It is recommended WCDSS create a policy construing the importance of prudently gathering and adding demographic information regarding children residing in the home or for a child who is born during an open case to the case record. Upon learning of a child's death, it would allow OCFS to immediately offer guidance and monitor casework practice surrounding the death of a child on an open case. Additionally, the case record would more accurately reflect case circumstances.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No