Child Fatality Report

Report Identification Number: RO-22-005

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

Issue Date: Jul 26, 2022

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Wayne
Gender: Male
Date of Death: 03/03/2022
Initial Date OCFS Notified: 03/03/2022

Presenting Information

The four-year-old subject child was diagnosed with non-life threatening Spina Bifida, requiring constant direct supervision. The subject child had been sick, requiring medical treatment; however, the mother and father failed to take the child for medical treatment. On 3/3/2022, the mother and father went shopping and left the subject child and surviving sibling home to be cared for by an unrelated home member. The unrelated home member left both children alone and unattended, in a separate room, for an unknown amount of time. Later that day, at approximately 7:00PM, the parents returned home and the father found the subject child in an unknown state. The father instructed the mother to call 911. EMS responded and performed CPR, and transported the subject child to the hospital. The hospital staff continued CPR; however, the subject child was pronounced deceased at 7:17PM. The father was providing conflicting information about what happened to the subject child.

Executive Summary

This fatality concerns the death of a 4-year-old male subject child that occurred on 3/3/22. The report contained allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter against the mother, father, 63-year-old unrelated home member, 61-year-old unrelated home member, 29-year-old unrelated home member and 23-year-old unrelated home member, as well as allegations of DOA/Fatality and Lack of Medical Care against the mother and father, and Lack of Supervision against the 29-year-old unrelated home member. At the time of his death, the subject child resided with his mother, father, and 1-year-old surviving sibling, as well as the unrelated home members. The father has a daughter, age unknown, who resides out of state.

Wayne County Department of Social Services (WCDSS) completed collateral contacts and casework activity and learned that on 3/3/22, the mother and father went to the store between 5:00-5:15PM and left the subject child and 1-year-old surviving sibling, who were asleep at the time, in the care of the 29-year-old unrelated home member. The unrelated home member watched TV in the same room where the children napped for approximately one hour, when he heard a pillow fall from the bed. The unrelated home member observed the subject child to awake and asked the subject child if he needed anything or wanted something to eat, but the subject child refused and stated he was tired. The subject child laid back down, and the unrelated home member left the bedroom. Approximately 10 minutes later, the parents arrived home and the father went to check on the children. The father observed that the subject child was unresponsive, attempted to wake the child, and then began chest compressions. The mother attempted to call 911; however, did not have a cellphone signal. The father put the subject child in the car with the mother and began to drive until the mother was able to get through to 911. The mother and father were instructed by 911 dispatch to pull over and wait for an ambulance. The ambulance transported the subject child to the hospital, where he was pronounced deceased at 7:17PM.

An autopsy was performed, and an official cause and manner of death were pending at the time the CPS investigation was closed; however, there were no external injuries observed. The final autopsy is pending a micro exam and toxicology. No criminal charges had been filed pertaining to the subject child's death at the time the CPS investigation closed.

The allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter were substantiated against the mother and father; however unsubstantiated against the four unrelated home members. The allegation of Lack of Medical Care against the mother and father, and allegation of Lack of Supervision against the 29-year-old unrelated home member were unsubstantiated. WCDSS found there was a fair preponderance of evidence to support that the condition of the home was a hazard for the subject child and 1-year-old sibling, and there were not appropriate sleeping accommodations for the

children. All household members were offered bereavement services. The mother and father initially expressed wanting to engage in counseling; however, by the time of case closure felt it was not necessary.

PIP Requirement

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

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:

Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Throughout the investigation, WCDSS learned that the father had a daughter who resided out of state. The record does not reflect that WCDSS explored the father's contact with that child, or assessed for her safety.

Legal Reference:	18 NYCRR 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/03/2022 **Time of Death:** 07:17 PM

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

County where fatality incident occurred: Wayne
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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? Yes

How long before incident was the child last seen by caretaker? 10 Minutes

At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:
☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **In Another Room**

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	4 Year(s)

Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Male	63 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	61 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Male	23 Year(s)

LDSS Response

WCDSS coordinated their investigation with LE, notified the DA's office and ME of the death, spoke with collateral sources and interviewed household members.

WCDSS interviewed the SM and SF, as well as the unrelated home members (UHM) on 3/4/22. The SM and SF reported the SC was diagnosed with Spina Bifida, as well as another medical diagnosis that resulted in chronic constipation. The SF reported the SC had been constipated for a week and half preceding his death and had appeared weaker over the last 3 weeks. The SM and SF denied seeking medical attention for the SC regarding those concerns and stated they planned on taking the SC to urgent care the following day if symptoms worsened.

The SM, SF, and 29yo UHM reported the SM and SF went to the store between 5-5:15PM on 3/3/22 to get the SC medicine to help his constipation. The SM and SF left the SC and 1yo SS home with the 29yo UHM while they went to the store. The UHM reported he was watching TV in the bedroom, while the SC and 1yo SS slept on the parents' queen-sized bed. Approximately one hour later, around 6PM, the UHM heard a pillow fall from the bed the CHN were asleep on and observed the SC to be sitting up, with his arms up straight in the air. The UHM asked the SC if he needed anything or wanted something to eat, but the SC declined, stating he was tired and laid back down. The UHM stated he turned off the TV and lights to allow the CHN to sleep better and left the room. The UHM reported he was in the kitchen and talked with his mother, the 61yo UHM, for about 10 minutes until the SM and SF arrived home. The SF went to the bedroom to check on the CHN and observed the SC's chest was not moving. The SF attempted to wake the SC but was unsuccessful. The SF began chest compressions on the SC, while the SM attempted to call 911. The SM did not have a cellphone signal; therefore, the SF brought the SC to the car with the SM and began to drive until the SM gained cellphone service and got through to 911. The SM and SF were instructed to pull over and wait for an ambulance, which arrived and transported the SC to the hospital, where he was later pronounced dead. The SF reported the SC had been lying on top of pillows on the parents' bed in just a diaper without any blankets covering him, and the 1yo SS had been asleep on the opposite corner of the bed. The SF noted that the SC's skin was hot, and he was observed to have white foam coming from his mouth. The SM and 29yo UHM corroborated these events. The 23yo UHM stated he heard his brother, the 29yo, ask the SC questions including if he needed anything; however, could not hear the SC's response. The 63yo UHM stated he heard commotion, and the 61yo UHM told him something had happened to the SC, but stated he is hard of hearing and did not hear anything else.

The SC's pediatrician confirmed the SM and SF had not reached out about the SC's condition; however, reported they were unable to say that if the parents had sought medical attention sooner that it would have prevented the outcome. The pediatrician did note that the SC had a life expectancy of 30 to 40 years old.

During the initial home visit, WCDSS observed the home to be unsafe and unsanitary for the 1yo SS and did not observe appropriate sleeping accommodations. The family moved out of the residence and stayed in a hotel for approximately one month. A preventive case was opened on 4/25/22 by WCDSS to assist the family in finding new housing; however, the preventive case was closed on 5/16/22 due to the family moving out of county and no longer needing housing assistance.

The 1yo SS was seen during multiple home visits and deemed to be safe with the SM and SF. WCDSS did not reflect in the case record that they explored the SF's contact with his daughter who resided out of state, or that her safety was assessed.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: Wayne County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060670 - Deceased Child, Male, 4 Yrs	060671 - Mother, Female, 29 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
060670 - Deceased Child, Male, 4 Yrs	060672 - Father, Male, 30 Year(s)	Lack of Medical Care	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060676 - Unrelated Home Member, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060676 - Unrelated Home Member, Male, 29 Year(s)	DOA / Fatality	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060672 - Father, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060671 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060677 - Unrelated Home Member, Male, 23 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060676 - Unrelated Home Member, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060674 - Unrelated Home Member, Male, 63 Year(s)	Lack of Medical Care	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060675 - Unrelated Home Member, Female, 61 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060676 - Unrelated Home Member, Male, 29 Year(s)	Lack of Supervision	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060674 - Unrelated Home Member, Male, 63 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
060670 - Deceased Child, Male, 4 Yrs	060672 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated

060670 - Deceased Child, Male, 4 Yrs	060672 - Father, Male, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
060670 - Deceased Child, Male, 4 Yrs	060671 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
060673 - Sibling, Male, 1 Year(s)	060672 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
060673 - Sibling, Male, 1 Year(s)	060676 - Unrelated Home Member, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
060673 - Sibling, Male, 1 Year(s)	060677 - Unrelated Home Member, Male, 23 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
060673 - Sibling, Male, 1 Year(s)	060672 - Father, Male, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
060673 - Sibling, Male, 1 Year(s)	060671 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
060673 - Sibling, Male, 1 Year(s)	060671 - Mother, Female, 29 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
060673 - Sibling, Male, 1 Year(s)	060674 - Unrelated Home Member, Male, 63 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
060673 - Sibling, Male, 1 Year(s)	060675 - Unrelated Home Member, Female, 61 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:

WCDSS made diligent efforts to interview the 61yo UHM; however, were unable to reach her until the time of case closure, at which time WCDSS interviewed her over the phone. WCDSS did not assess the half sibling, who lived out of state.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

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?	☐	☒	☐	☐

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Preventive 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:
WCDSS provided the parents with resources on behalf of the 1-year-old surviving sibling.

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

fatality? Yes
Explain:
WCDSS offered and provided resources for counseling and various community services to the parents, household members and maternal grandparents. The mother and father initially expressed a desire to engage in grief counseling; however, at the time of case closure stated they did not feel it was needed.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/28/2021	Sibling, Male, 1 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 1 Years	Mother, Female, 30 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 30 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 29 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 29 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Male, 4 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 4 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged the mother and father put food on the floor for the subject child and 1-year-old sibling. The father always put the sibling on his shoulders, and as a result the sibling was bowlegged and had difficulty walking. The mother and father tied the sibling's arms in his pants to restrict him from getting into things, and as a result the sibling was unstable on his feet, fell and hit his face on objects in the home. The sibling sustained a busted lip and bump to the arm, which required emergency attention; however, the parents did not seek medical care.

Report Determination: Unfounded | **Date of Determination:** 01/28/2022

Basis for Determination:
WCDSS determined there was no credible evidence to substantiate the allegations. The father reported he did put the

sibling on his shoulders at times, and the sibling loved it. The father denied putting the sibling's arms in his pants or that the sibling was restricted. Both children were observed to be free of marks or bruises.

OCFS Review Results:
WCDSS initiated their investigation in 24-hours, interviewed the mother and father, contacted collateral sources, and saw the children. WCDSS contacted medical collaterals and confirmed there were no medical concerns for the children. The record does not reflect that WCDSS addressed concerns of drug paraphernalia and substance use in the home, and the unrelated home member was not added or notified of the report.

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

Issue:
Case record contains information that is relevant, useful, factual and objective

Summary:
WCDSS documented in their investigation conclusion that the father denied the allegations of restricting the sibling's arms; however, in an interview with WCDSS, the father admitted he pulled the sibling's pants above his arms in a playful manner, and that the sibling did fall and bust his lip; however that was a separate incident. The interview did not reflect if medical attention was needed.

Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:
WCDSS records must contain information that is relevant, useful, factual, and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Issue:
Failure to provide notice of report

Summary:
WCDSS did not add the unrelated home members to the report, despite them living in the home. WCDSS observed drug paraphernalia in the unrelated home member's area of the residence, which was visible from the path to the family's rented room.

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:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
It was documented in the record that during a visit to the residence, WCDSS observed drug paraphernalia on the unrelated home member's desk and that a service provider had observed the father smoking marijuana in the kitchen of the residence while the children were home; however, the record does not reflect this being addressed with the parents or any household members.

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

Action:
In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. WCDSS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/28/2021	Deceased Child, Male, 3 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 3 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 3 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged the mother and father rented a small room in a home from a friend. The mother and father smoked cigarettes and marijuana in the small room with the subject child and 1-year-old sibling. The room had black mold on the ceiling; the home was hoarded, there were broken windows, and the parents failed to address the situation.

Report Determination: Unfounded | **Date of Determination:** 12/28/2021

Basis for Determination:
WCDSS determined there was no credible evidence to substantiate the allegations. The mother and father denied using marijuana in the bedroom and there were clear pathways throughout the home, without hazards such as mold or broken glass observed. The family was waitlisted for an apartment.

OCFS Review Results:
WCDSS conducted a CPS history search, interviewed the mother and father, assessed the home and children, and contacted collateral sources. The 7-day safety assessment as completed one day late, on 10/6/21. There was no documentation that WCDSS attempted to interview the subject child despite it being age appropriate, and the unrelated home members were not added or notified of the report.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day safety assessment was completed one day late, on 10/6/21.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Within seven days of receiving a report, WCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
The record did not reflect that WCDSS attempted to interview the subject child, despite it being age appropriate and it being documented that the subject child interacted verbally with WCDSS.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
WCDSS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

Issue:
Failure to provide notice of report
Summary:
WCDSS did not add the unrelated home members to the report or notify them in writing, although it has been documented that the family resided in the unrelated home members residence.
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)
05/13/2021	Deceased Child, Male, 3 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Deceased Child, Male, 3 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 11 Months	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Male, 11 Months	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 3 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Deceased Child, Male, 3 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 11 Months	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Male, 11 Months	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 29 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 3 Years	Father, Male, 29 Years	Lack of Medical Care	Substantiated	

Report Summary:
The SCR report alleged the mother and father rented a room in a home from friends and lived in one bedroom at the back of the house. The home was hoarded, had items piled high on tables and was infested with bugs. The parents, sibling and

subject child shared common areas of the home including the kitchen and bathroom, which exposed the children to unsanitary and unsafe conditions. The mother and father did not provide the children with a safe and clean-living environment.

Report Determination: Indicated | **Date of Determination:** 07/28/2021

Basis for Determination:
WCDSS determined there was enough credible evidence to substantiate the allegations. The home was observed to be very cluttered and the room the family lived in had limited walking space, which was addressed with the parents several times throughout the investigation. The mother and father were unable to show WCDSS a food supply on the first visit and refused to provide collateral contacts that could confirm food was being obtained. WCDSS also learned throughout the investigation that the subject child had not been seen by a pediatrician since 2020, or by specialists since 2018 and 2019, which were necessary since he was diagnosed with Spina Bifida.

OCFS Review Results:
WCDSS conducted numerous visits to the residence, interviewed both parents on the allegations of the report, and made collateral contacts. WCDSS made referrals to community resources; however, services were terminated due to lack of contact with the family.

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

Issue:
Failure to provide notice of report

Summary:
WCDSS did not add the additional unrelated household members to the case despite that it was documented the family shared common areas with the unrelated household members and the condition of the entire home was noted as a concern in the initial 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.

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/05/2020	Sibling, Male, 1 Days	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:
The SCR report alleged that the mother gave birth to the 1-year-old sibling and had a positive toxicology for marijuana at the time of delivery. The sibling's toxicology was still pending.

Report Determination: Unfounded | **Date of Determination:** 06/22/2020

Basis for Determination:
WCDSS determined there was no credible evidence to substantiate the allegation. The mother tested positive for marijuana at the time of the sibling's birth; however, the sibling tested negative for all substances and had no noted medical concerns at the time of discharge. The mother reported that she smoked marijuana to help with her nausea throughout her pregnancy, and that she would no longer need to smoke since she gave birth and no longer has morning sickness. Both parents denied they smoked in the presence of the subject child.

OCFS Review Results:
WCDSS initiated their investigation in 24-hours, contacted the source and assessed the safety of both children. WCDSS

interviewed all household members; however, did not add the unrelated household member despite the parents residing in his home. WCDSS was made aware the subject child had Spina Bifida during the investigation and confirmed with the pediatrician that both children were up to date medically, and there were no noted medical concerns at that time.

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

Issue:
Failure to provide notice of report

Summary:
Although WCDSS did conduct an interview of the unrelated home member, WCDSS did not add him to the investigation or notify him in writing despite the mother and father residing in his home.

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.

[redacted]

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

There was one unfounded report with allegations of IG in 2016 against the 61-year-old unrelated home member regarding the 23-year-old unrelated home member; however, it was deemed the 23-year-old was legally an adult at the time of the report and the case was closed.

Known CPS History Outside of NYS

There is no known history outside of New York State.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

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

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