Child Fatality Report

Report Identification Number: SY-18-008

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

Issue Date: Aug 29, 2018

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		

Case Information

Report Type: Child Deceased
Age: 7 month(s)
Jurisdiction: Broome
Gender: Male
Date of Death: 03/03/2018
Initial Date OCFS Notified: 03/03/2018

Presenting Information

On 3/3/2018, an SCR report was received and alleged the 7-month-old SC was found deceased, while in the SM's care. The SC was found lying face down on the SM's bed surrounded by pillows. The SM then picked the SC up and it was obvious the SC was already deceased as rigor mortis had set in. It was unknown exactly when the SC passed away. The last time the SC was known to be alive was on 3/1/18. The SC was an otherwise healthy child and did not have any preexisting conditions or health issues prior to death. The SM was the sole caretaker of the SC. The SM was under the influence of an unknown drug at the time the SC's body was discovered on 3/3/18. The cause of death was unknown.

Executive Summary

On 3/3/18, Broome County Department of Social Services (BCDSS) responded to an SCR report concerning the death of a 7-month-old male SC. BCDSS learned through a SCR history check that there was an open Preventive Services/CPS Services case with Wayne County Department of Social Services (WCDSS). The case had been open since 8/2/17 and involved concerns for the SM's ability to care for the SC due to drug/alcohol misuse. The SC remained in the hospital after birth due to withdrawal syptoms and the SM was unable to adaquately care for the SC.

On 3/3/18, the SC was found deceased when LE responded to a call to conduct a welfare check on the SM and the SC. LE found the SC in the SM's bedroom and the SC was already deceased. LE called for assistance. EMS arrived and determined the SC was already dead and there nothing they could do. The SM was transported to the hospital to be evaluated. A warrant was obtained and the apartment was declared a crime scene, and the SC was transported to the ME's office for an autopsy.

BCDSS assessed the safety of the 2 SS and learned that the 13yo SS was in the sole custody of the Maternal Grandparent's (MGP's) under an Article 6 custody petition since 2015. The 4yo SS was in the sole custody of the Paternal (PGP's). The SM had no unsupervised contact with either child. After the fatality, the SM had no other children in her care. BCDSS learned the SM did not know who the BF of the SC was.

The ME's report was not completed and cause and manner of death were still pending at the time of the writing of this report. The ME reported to the BCDSS that the SC was face down after death based on lividity. The ME stated the SC possibly died in the bed or was placed in the bed after he died. The ME reported there were no signs of trauma found on the body.

BCDSS gathered information from all relevant collaterals, such as the SM, family members, the SM's service providers, the SC's pediatrician and WCDSS.

At the time this report was written the case remained undetermined and the investigation was ongoing. There were no arrests.

WCDSS had an open Protective case as well as an open Preventive case at the time of the reported fatality. WCDSS had not had face-to-face contact with the SC or the SM since 12/1/17. WCDSS had not assessed the home environment of the SC since the SM and the SC moved to Broome County on 12/18/17. WCDSS planned to refer the case for Preventive

Services to BCDSS but decided to wait for the signed order from the Family Court Judge before making the referral as noted in the connections case record.

PIP Requirement
WCDSS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the WCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, WCDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The case remained undetermined.

Was the decision to close the case appropriate? Unknown

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 case remained open.

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: 03/03/2018 **Time of Death:** Unknown

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

County where fatality incident occurred: Broome
Was 911 or local emergency number called? Unknown
Did EMS 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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	7 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	41 Year(s)

LDSS Response

On 3/3/18, BCDSS received an SCR report concerning the SC's death. BCDSS initiated their investigation by contacting LE, ME and verifying the DA had been contacted. BCDSS checked the SCR history and there was an open services case in WCDSS involving SM and SC. BCDSS learned that on 8/4/2017, SC was placed in FC due to SM's ongoing illegal drug use. SM was in an inpatient Tx program and on 11/17/17, the Family Court Judge returned SC to SM. WCDSS transferred the case from FC to PV services on 12/1/17. On 12/18/17, SM and SC were discharged to a supportive living program in BCDSS. WCDSS was in contact via phone with SM's service providers and SM. WCDSS planned to refer the case for Preventive Services to BCDSS, when the signed order was received from Family Court. WCDSS had no face-to-face contact with SM or SC from 12/1/17 to the date of SC's death on nor did they request BCDSS to do so. SC's home environment in Broome County had not been assessed by WCDSS.

BCDSS assessed the safety of the 2 SS. BCDSS determined the SS were protected as they both resided in the care and custody of relatives, with no unsupervised contact with SM. BCDSS obtained Family Court documents and spoke with the GP's. The SM had no other CHN in her care.

BCDSS coordinated with LE, and jointly investigated the circumstances of the fatality. Through interviews with LE, SM's roommate, MGM and services providers, it was learned the last time SC was seen alive was on 3/1/18 by service providers and the roomate. On 3/3/18, MGM called LE at 2:22PM to do a welfare check on SM and SC. MGM was concerned as she had not been able to contact with the SM since 3/1/18. LE told BCDSS when they arrived at the apartment, SM was struggling to open the door. This went on for 15 minutes. SM finally handed the keys out the window for LE to open the door. When LE entered the apartment, they asked SM where the SC was and she took them the bedroom. SM picked SC up and held his face against her chest and said he is fine. LE requested to see the baby and SM turned the SC so they could see him. LE said SC was already dead. LE observed lividity on SC. The SM became hysterical and was removed to the living room. LE called in to the office assistance from Detectives and LE called EMS at this time. It was determined SC was deceased. LE had SM transported to the hospital, she considered a person unable to care for themselves due to possible drug/alcohol issues and needed Tx.

BCDSS observed the home to be clean and with no visible safety hazards or odors. There was a portable crib observed with numerous items in it. There were multiple pillows and blankets on the bed. Numerous medications were collected and documented by LE.

BCDSS interviewed SM at the hospital but she could not provide a coherent account of the events leading up to the fatality. The hospital admitted SM, as she threatened to harm herself. SM's admitting lab work was refused. SM's urine screen was negative and the BAC was negative. BCDSS conducted a follow up interview with SM. SM told BCDSS she found SC dead in his portable crib and said afterwards she snapped and took SC to bed with her. SM said she did not call anyone because he was already dead. SM told BCDSS she had not taken one of her medications for several days and was in withdrawal. This was not verified the medical provider. The SM was released back her program. SM did not know who the BF of the SC was.

The SM had received referrals from her service providers. BCDSS gathered information from LE, medical professionals, the pediatrician and service providers.

ME's findings and the cause and manner of death were pending at the time of the writing of this report. The ME told BCDSS based on lividity the SC was dead approximately 6 to 8hrs when found. There were no signs of trauma found on the body. Based on the lividity, SC either died in the bed or was placed face down in the bed after his death. The toxicology results were still pending

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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

047215 - Deceased Child, Male, 7 Mons	047216 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Pending
047215 - Deceased Child, Male, 7 Mons	047216 - Mother, Female, 37 Year(s)	DOA / Fatality	Pending
047215 - Deceased Child, Male, 7 Mons	047216 - Mother, Female, 37 Year(s)	Parents Drug / Alcohol Misuse	Pending

CPS Fatality Casework/Investigative Activities

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

BCDSS did locate and determine that there were two SS that were in Article 6 Custody of their GP's and had been since 2015. The SM did not have unsupervised contact with the SS's.

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	☒	☐	☐	☐

Explain:
The SM was offered and receiving services through her supportive living program. The SM was referred to bereavement services through her mental health provider.

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:
The SS's were already in Article 6 custody with their respective GP's since 2015.

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:
The SM was already involved with services through her supportive living program. The SM's mental health provider gave the SM referrals for bereavement services and continued to provide mental health services and drug/alcohol Tx.

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 MGP's had sole custody of the 13yo SS and the PGP's had custody of the 4yo SS. BCDSS did locate these children and assess their safety. The SM had no other CHN in her care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The SM was receiving services through her mental health provider and BCDSS was aware of this and had documented this in the connections case record.

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?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
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)	Allegation Outcome	Compliance Issue(s)
08/02/2017	Deceased Child, Male, 14 Days	Mother, Female, 37 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
There was concern the SM was not able to provide adequate care for the 14-day-old SC. The SC was in the NICU since birth. The SM rarely visited and when she did visit she was unable to follow simple instructions regarding the care of the SC.

Report Determination: Indicated | **Date of Determination:** 08/28/2017

Basis for Determination:
WCDSS investigated allegation of IG and Sub against the SM for the SC. Based on interviews with collateral contacts it was determined the SM who had a long history of drug use had relapsed and was using drugs again. The SM was tested by the Tx program she was in and tested positive for cocaine use and was sent to jail. The SC was in the NICU being treated for withdrawal symptoms and the SM failed to visit or demonstrate to hospital staff that she was able to care for the SC. WCDSS filed an Article 10 neglect petition in Family Court on 8/3/17. The SC was placed in Foster Care and SM had supervised visits only. The case was IND and opened for services.

OCFS Review Results:
The source was contacted and CPS history was reviewed. All appropriate notice letters were sent. The subjects and other adults named were interviewed face to face and the SC was seen. Notes were documented contemporaneously in the record. There was regular supervisor review noted in the case record.

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

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

SCR report received 6/7/06 with allegations of IG, PD/AM and IG against the SM and allegation of IG against the BF for a

SS. The allegations against the SM were Unsub and the allegation of IG was Sub against the SF. The case was closed no services needed.

SCR report received 7/17/06 with allegations of other/ Court ordered investigation about the SM and the BF for a SS. The allegation was Unsub and the case was closed. No services were needed.

SCR report received 6/25/07 with allegations of PD/AM and IG against the SM for a SS were Sub. The case was IND and closed. The SM was referred to community based services.

SCR report received 4/19/09 with allegations of L/B/W and IG against the SM and the MGP for the SS. The case was converted to the FAR track. The case was closed.

SCR report received 3/19/10 with allegations of IG and L/B/W against the MGP for a SS were Unub. The SM was listed with no role. The case was UNF and closed. There were no services needed.

SCR report received 6/10/11 with allegations of IF/C/S, PD/AM and IG against both parents for a SS. The case was converted to the FAR track. The case was closed.

SCR report received 12/10/12 with allegations of PD/AM and IG against SM and the BF for a SS were Unsub. The case was UNF and closed. There were no services needed.

SCR report received 1/30/15 with allegations of IG against the SM, BF, and PGP for the SS and PD/AM against the SM for the SS. The case was IND and closed. There were no services needed.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 12/01/2017

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 12/01/2017

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☐	☐	☒

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐

Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐

Additional information, if necessary:
WCDSS had an open Preventive Services case at the time of the SC death on 3/3/18. The case was open from 12/1/17 to 3/3/18 with no face to face contact or home visit with the SC or the SM.

Required Action(s)

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

Issue:	Provision of Preventive services
Summary:	WCDSS had an open Preventive Services case at the time of the death of the SC. WCDSS had no face to face contact with the SM or the SC from 12/1/17 to 3/3/17.
Legal Reference:	423.4(d)
Action:	WCDSS will make all required contacts as per regulation.
Issue:	Failure to Monitor
Summary:	WCDSS failed to monitor services as per regulation.
Legal Reference:	18 NYCRR 432.2(b)(5)
Action:	WCDSS will monitor the provision of services as per regulation.

Preventive Services History

On 12/1/17, a court-ordered Preventive Services case opened via transfer from Foster Care case (see below). The SM was to continue with Tx. The SM and the SC were discharged on 12/18/17 to a supportive living Tx program for women and children. This program was located in Broome County. On 1/12/17, Family Court appearance with the Wayne County Family Court Judge. All parties agreed to proposed disposition and the SM appeared via phone and waived her right to a hearing and agreed to all requirements written in the order. WCDSS was to refer the case to Preventive Services in Broome County when the order was signed by the Family Court Judge. The Preventive Services case remained open with

WCDSS with no face to face contact with the SM or the SC from 12/1/17 to the date of the SC's death on 3/3/18. On 3/1/18, WCDSS received the signed Family Court Order.

Foster Care Placement History

On 8/4/2017 the SC was removed via Article 1022 of the Family Court Act. The Family Court Judge after hearing testimony granted removal and the SC was placed in the custody of the Commissioner of Wayne County Department of Social Services (WCDSS). Subsequently, on 8/9/17, an Article 10 abuse/neglect petition was filed in Family Court against the SM. Efforts were made by WCDSS to prevent placement and contacted the MGP's and the PGP's who declined to take custody of SC. Paternity had not yet been established and the SM was uncertain about the parentage of the SC. The SC was placed in FC due to the SM's ongoing illegal drug use. At the time of the SC's placement, the SM was in jail for violating an order through drug treatment court. The SM was discharged from jail to an inpatient Tx facility. On 8/31/17, the SM was granted visitation every other weekend from Friday to Monday morning. The SM was ordered to continue with inpatient Tx, Mental Health Tx and parent training. These services were being provided through the Tx program. On 11/16/17, the Family Court judge ordered the return of the SC to the SM, with court ordered Preventive Services. On 12/1/17, the Foster Care worker transferred the case to the Preventive Services worker. The SM and the SC continued to reside in an inpatient Tx facility.

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
Unknown	Adjudicated Neglected	Order of Supervision
Respondent:	047216 Mother Female 37 Year(s)	
Comments:	WCDSS was had an open CPS/Preventive Services case at the time of the fatality.	

Additional Local District Comments

BCDSS concurs with OCFS' findings. BCDSS conducted a thorough investigation by assessing the safety of SS, gathering information from relevant sources; the subject mother, family members, service providers, child's DR. and Wayne County DSS.

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