Child Fatality Report

Report Identification Number: AL-18-017

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

Issue Date: Feb 22, 2019

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: 2 month(s)
Jurisdiction: Schenectady
Gender: Male
Date of Death: 07/18/2018,estimated
Initial Date OCFS Notified: 08/16/2018

Presenting Information

An SCR report was received on 8/16/18 with concerns the mother had an extensive history of heroin use, and on 7/17/18, became highly impaired while caring for her 3-month-old child. The report alleged the mother then placed the child in bed with her and woke up on 7/18/18 to find the child unresponsive and deceased. The mother did not seek medical attention and failed to contact the appropriate authorities. Further, the report alleged the mother kept the body of the child in a bassinet in the home for a period of 1 to 2 days. The mother then wrapped the child in plastic bags and placed him in the back yard of her home. The child's body was not discovered until 8/9/18, and it was unknown if the child had sustained any injuries or the direct cause of the death.

Executive Summary

This fatality report concerns the death of a 3-month-old subject child (SC) that occurred on or around 7/18/18. A report was made to the SCR on 8/16/18, with allegations of DOA/Fatality, Parent's Drug/Alcohol Misuse, Lack of Medical Care, and Inadequate Guardianship against the subject child's mother (SM). Schenectady County Department of Social Services (SCDSS) received the fatality report and conducted a thorough investigation into the subject child's death. SCDSS had been involved with the mother and subject child since 7/3/18, as they were investigating concerns the mother was using and trafficking drugs and leaving the subject child unsupervised. During this investigation, SCDSS was able to assess the safety of the subject child on three occasions. After the last face to face contact on 7/17/18, SCDSS made numerous other attempts to continue to assess the safety of the subject child; however, the mother failed to produce him or provide locating information. On 8/9/18, Law Enforcement discovered the body of the subject child in the back yard of the mother's residence and the mother was arrested. The subject child's body was so badly decomposed that an autopsy could not be performed successfully. At the time of this writing, additional testing by an FBI Forensic Anthropologist remained ongoing to try to determine the cause and manner of the subject child's death.

In May 2018, Saratoga County Child Protective Services (SaCDSS) became involved with the family due to the mother's request for services. Per the mother's account, the subject child was born prematurely in a hotel room in Saratoga County on 4/20/18. There was no record the mother received prenatal care, and the subject child was not evaluated by medical professionals until approximately 21 days after his birth. The child was diagnosed as Failure to Thrive on 5/11/18, and medical professionals provided the mother with all necessary treatment recommendations moving forward, with which the mother did not fully comply.

It was discovered the mother had a lengthy and serious history of drug abuse and neglect, and was known to both Saratoga and Schenectady County Departments of Social Services. The mother had a 14-year-old daughter who was in the care and custody of her biological father, and with whom she had little to no contact.

Due to the nature of the case and the ongoing criminal investigation, details surrounding the events that led up to the subject child's death were not revealed to SCDSS. From the time the investigation began to the time of its closure, SCDSS attempted to interview SM as well as the potential biological fathers of the subject child. SCDSS also spoke with numerous collateral sources and assessed the safety of the 14-year-old surviving sibling. Appropriate services were offered to the sibling and her family. On 8/14/18, the mother was charged with Endangering the Welfare of a Child, Tampering with Physical Evidence, and Concealment of a Human Corpse. On 10/24/18, the mother was additionally charged with Manslaughter 1, Manslaughter 2, and Murder. SCDSS found evidence to indicate all allegations in the report and closed their investigation.

PIP Requirement
Review of CPS history resulted in citations for both SCDSS and SaCDSS. SCDSS and SaCDSS will submit Program Improvement Plans (PIP) to the Regional Office within 30 days of issuance of this report. These PIPs will identify what action(s) SCDSS and SaCDSS have taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, SCDSS and SaCDSS will review the plan(s) and revise as needed to further address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
At the time of case closure, there were no other children that resided in the household, nor were there any other children named on the report. All required safety assessments were completed timely and sufficiently. SCDSS' decision to substantiate all allegations and close the case was appropriate.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The level of casework activity was commensurate with the case circumstances. The final determination and decision to close the case were 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: 07/18/2018 Date Estimated **Time of Death:** Unknown

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

County where fatality incident occurred: Schenectady
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? 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? 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	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)

LDSS Response

On 8/16/18, SCDSS received a report regarding the death of SC. SCDSS initiated their investigation within 24 hours and coordinated their efforts with LE. SCDSS learned SC resided with SM and the two had recently moved to Schenectady County. There were no other children that lived in the home. SC had one surviving half-sibling (14 years old), who was in the care and custody of her biological father and had had no contact with SM since December 2017, with sporadic contact prior to that. It was determined the SS had never met the SC and had no knowledge of his death. SM also had another child, now 3 years old, who was freed for adoption in 2017 after SM's parental rights were terminated in August 2016.

Although the fatality report was received on 8/16/18, SCDSS had been involved with the family since July 2018, as they were investigating a separate SCR report with allegations SM was using and trafficking drugs. During that investigation, SCDSS assessed the safety of SC on three occasions, the last being 7/17/18. After this date, SCDSS made numerous attempts to assess the wellbeing of SC, but SM would not produce the child during home visits, nor provide any locating information. SCDSS obtained an Access Order from Schenectady County Family Court on 8/7/18. When SCDSS went to SM’s home on that same date, they were told by another tenant SM may have sold SC for heroin. LE became involved in the case at that time. On 8/8/18, LE questioned SM, and on 8/9/18, LE found SC deceased, inside of a duffel bag, in the back yard of SM’s residence. The ME reported SC’s body was so badly decomposed a gender could not be identified, and there was no way to determine a direct cause of death; the body was sent to a forensic specialist for further testing. Subsequently, SM was arrested and arraigned in criminal court on 8/15/18. SM was remanded to the Schenectady County Jail.

On 8/16/18, SCDSS worked diligently to locate and assess the safety of the SS. A home visit was completed and no concerns were noted. SCDSS interviewed the SS's biological father, and he explained his knowledge of SM's extensive history with drug use and that he felt SS to be unsafe around SM. SCDSS offered the family grief counseling which was declined.

On 8/17/18, SCDSS met with SM in the Schenectady County Jail. SCDSS reviewed the fatality report with SM, and SM reported she "did not do anything wrong." SM signed releases of information for collateral sources. Details surrounding SC's death or the events leading up to it were not discussed, as SM's attorney advised her not to speak to SCDSS about her pending case.

Diligent efforts were made on behalf of SCDSS to determine the biological father to SC. Although SM named two possible fathers, one of which resided in California, neither were listed on SC's birth certificate. At the time this report was issued, paternity had not yet been established. Despite this, SCDSS exhibited excellent casework practice by trying to locate and interview the potential fathers. The individual that lived out of state could not be located; however, the other alleged father was local and met with caseworkers. This individual could not provide any information regarding SC or his death, as he reported he had not had contact with SM in several months and was unaware she had been pregnant.

SCDSS observed an interview between SM and LE on 8/21/18. During this interview, SM reported on the evening of or around 7/18/18, she was home alone with SC, used a bag of heroin, and fell asleep with SC in bed with her. SM reported to LE when she awoke the next morning, SC was deceased. She informed LE she kept SC in his bassinet for approximately two days before wrapping him in plastic shopping bags. She then placed him in a duffel bag and put him in the back yard of her apartment building. LE discovered the body of SC in the duffel bag on 8/9/18.

SCDSS completed a thorough investigation into the death of SC. Interviews were completed with those named on the report, as well as an abundance of collateral sources. At the time this report was issued, the criminal case surrounding the death of SC was being heard in Grand Jury. Due to the sensitive nature of the case, additional details surrounding the charges against SM and the criminal proceedings of such could not be disclosed to SCDSS. The cause and manner of SC's death remained pending.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: The fatality investigation was conducted by the Schenectady County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Schenectady 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
048454 - Deceased Child, Male, 2 Mons	048455 - Mother, Female, 38 Year(s)	Parents Drug / Alcohol Misuse	Substantiated

048454 - Deceased Child, Male, 2 Mons	048455 - Mother, Female, 38 Year(s)	Lack of Medical Care	Substantiated
048454 - Deceased Child, Male, 2 Mons	048455 - Mother, Female, 38 Year(s)	DOA / Fatality	Substantiated
048454 - Deceased Child, Male, 2 Mons	048455 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated

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:

Progress notes were entered contemporaneously and all appropriate collateral sources were contacted. There were no First Responders as the SC was already deceased. The LE response was considered a "search and recovery."

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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:
SCDSS was granted an Access Order through Family Court after SM refused to produce SC during several casework contacts. Appropriate services were offered to the family of the surviving half-sibling but declined. SM remained incarcerated at the time of this writing, and it is unclear what services, if any, she would be receiving while in jail.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
08/14/2018	SM	Pending	Unknown
Comments:	SM faced several charges regarding the death of SC. The criminal investigation and criminal court proceedings remained ongoing at the time of this writing.		

Criminal Charge: Other - Tampering with Physical Evidence (Class E Felony) **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
08/14/2018	SM	Pending	Unknown
Comments:	SM faced several charges regarding the death of SC. The criminal investigation and criminal court proceedings remained ongoing at the time of this writing.		

Criminal Charge: Other - Concealment of a Human Corpse (Class E Felony) **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
08/14/2018	SM	Pending	Unknown
Comments:	SM faced several charges regarding the death of SC. The criminal investigation and criminal court proceedings remained ongoing at the time of this writing.		

Criminal Charge: Manslaughter **Degree:** 1			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**

10/24/2018	SM	Pending	Unknown
Comments:	SM faced several charges regarding the death of SC. The criminal investigation and criminal court proceedings remained ongoing at the time of this writing.		

Criminal Charge: Manslaughter **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
10/24/2018	SM	Pending	Unknown
Comments:	SM faced several charges regarding the death of SC. The criminal investigation and criminal court proceedings remained ongoing at the time of this writing.		

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
10/24/2018	SM	Pending	Unknown
Comments:	SM faced several charges regarding the death of SC. The criminal investigation and criminal court proceedings remained ongoing at the time of this writing.		

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:
Services were offered to the surviving half-sibling and her family but declined. SM was incarcerated shortly after the fatality report was made, and it is unknown what services, if any, she would be receiving in jail.

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? N/A
Explain:
The surviving half-sibling was assessed for safety, and her father was interviewed. The father denied the need for any additional services for his daughter, as she had not had any recent contact with SM, nor had she ever met the SC.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
At the time of this writing, SC's biological father remained unknown and SM was incarcerated. Therefore, it is unclear what services SM will be receiving, if any, while in custody.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? 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)
07/03/2018	Deceased Child, Male, 2 Months	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 2 Months	Mother, Female, 38 Years	Lack of Supervision	Substantiated	
	Deceased Child, Male, 2 Months	Mother, Female, 38 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
Schenectady County Department of Social Services (SCDSS) received this report, as well as a subsequent report on 7/7/18, with concerns SM was using and trafficking drugs while caring for SC. There were further concerns SM was breastfeeding SC after using drugs, and was also leaving SC unsupervised at the home while she went to the store. During this investigation, it was discovered SC had died, and the separate fatality report was called in.

Report Determination: Indicated **Date of Determination:** 08/27/2018

Basis for Determination:
SCDSS found evidence to support the allegations and appropriately indicated the report. SCDSS determined the SC passed away approximately 14 days into this investigation, and there were concerns noted by collateral sources with SM's drug use and lack of care for SC. SCDSS sought an Access Order when they were unable to see SC and SM would not produce him. SM also appeared unstable as she stayed in various hotels and would not return home for several days/weeks at a time.

OCFS Review Results:
OCFS agreed with the determination of this case. The 7 Day Safety Assessment was not completed until 7/23/18. Several progress notes were entered more than one month after event dates.

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 due by 7/10/18, but not completed and approved until 7/24/18.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Within seven days of receiving a report, SCDSS 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:
Timely/Adequate Case Recording/Progress Notes
Summary:
Several progress notes were entered more than one month after the event date.
Legal Reference:
18 NYCRR 428.5
Action:
SCDSS will enter progress notes contemporaneously as events occur.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/11/2018	Deceased Child, Male, 1 Months	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 1 Months	Mother, Female, 38 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Male, 1 Months	Mother, Female, 38 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 1 Months	Mother, Female, 38 Years	Malnutrition / Failure to Thrive	Substantiated	

Report Summary:
Saratoga County Department of Social Services (SaCDSS) received this report with concerns SC, 3-weeks-old at the time, presented at an urgent care as failure to thrive. Medical staff recommended SC be admitted into the hospital; however, SM and SC left against medical advice when the nurse went to tend to another patient. The role of SC's father was unknown.

Report Determination: Indicated | **Date of Determination:** 07/12/2018

Basis for Determination:
SaCDSS interviewed SM, observed SC on multiple occasions, and followed up with collateral sources. SaCDSS found evidence to support the allegations in the report and appropriately indicated the case.

OCFS Review Results:
There were multiple casework practice deficiencies throughout SaCDSS' investigation. Case history revealed SM had three children, including SC. The history included CPS involvement that led up to SM's recent (2016) Termination of Parental Rights (TPR) of her then 2-year-old son due to non-compliance with treatment for her addictions. Further, history showed SM did not currently have custody of her older daughter; however, the CPS history check was not completed by SaCDSS until 7/5/18.

SM initially claimed she gave birth at Saratoga Hospital, but no record of this or any care for SM was found. It was discovered, per SM's report, SM gave birth to SC prematurely in a hotel room on 4/20/18, and sought no medical attention for herself or SC until approximately 21 days later (5/11/18). SM left the medical facility against medical advice, despite the infant's diagnosis of failure to thrive, only presenting the SC at the hospital 9 hours later after CPS intervention; however, SaCDSS selected a Safety Factor 2 for the 7 Day Safety Assessment. Based upon SM's extensive history and her actions on the date the report was received, immediate CPS intervention was necessary to protect the SC, and a Safety Plan should have been implemented to continue such protection. Additionally, there was no consultation with their legal department to consider Family Court action to further protect this extremely vulnerable infant at any time throughout this investigation.

There were no documented attempts to locate or speak with SC's alleged father, named on the report, nor were there any attempts to interview SM's friend who appeared to take an active caretaking role with SC. Multiple services were offered and SM was initially marginally compliant with recommended medical treatment for the SC. As time went on, SM again failed to comply with her own treatment and began to miss medical appointments for the SC. Regardless, SaCDSS closed their investigation with a Safety Decision 2, which stated no controlling interventions were necessary to keep SC safe.

At the time of case closing, SaCDSS was aware a separate investigation was open regarding SM and SC in Schenectady County; however, the urgent concerns that arose shortly before SaCDSS closed their case were not addressed with SM, nor were communications between the counties around these concerns adequately documented in the case record.

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

Issue:

Review of CPS History

Summary:

A CPS history review was not documented until 7/5/18, 55 days into the investigation.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

Within 1 business day of a report, SaCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child's sibling, and, for indicated reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.

Issue:

Assessment as to need for Family Court Action

Summary:

SM had a history of losing custody of her CHN, including TPR. SM gave birth to SC in a hotel and sought no medical attention. On 5/11/18, SM left against medical advice when staff felt SC needed hospitalization; staff expressed "grave concern" for SC. It took SM nearly 9 hours before taking SC to the ER, only with CPS intervention. SaCDSS did not consult with their legal department during the investigation.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:

The child protective service worker shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

SaCDSS selected a Safety Decision 2 for both required Safety Assessments, implying no controlling interventions were necessary to keep SC safe. Due to the concerns noted throughout the investigation, a higher decision was necessary and a Safety Plan should have been implemented. By the end of the investigation, SM was again not complying with medical needs for SC, yet SaCDSS again selected a Safety Decision 2, and did not feel the case circumstances rose to the level of needing a Safety Plan.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

Investigations conducted by SaCDSS must include assessments of the safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment in the form and manner provided by OCFS. If any child is assessed to be unsafe, SaCDSS must undertake immediate and appropriate controlling interventions to protect the child(ren).

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

Although the record clearly showed some contacts with medical providers, documented contacts were not commensurate with the concerns in this case.The pediatrician informed SM the SC needed to be be seen twice a week. SaCDSS did not document appropriate follow-up to confirm SM was following through with these recommendations.

Legal Reference:

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

Action:
SaCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
Toward the end of their investigation, SaCDSS obtained information from collateral sources that SM had again begun failing to follow through with SC's medical appointments/needs. Due to SM's initial failure to follow through with medical needs of her Failure to Thrive child without exhaustive CPS intervention on 5/11/18, her non-compliance with such at the end of the investigation again placed SC at future risk of harm. SaCDSS did not address this with SM prior to closing the case.

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

Action:
Prior to making a determination, SaCDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

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

5/6/15-IND allegations of IG and PD/AM against SM and PS regarding the now 14 yo SS and SM's other child that was freed for adoption.
11/25/14-IND allegations of IG and L/B/W against SM regarding SS.
6/9/14-UNF allegations of IG, L/B/W, and OTHER against SM regarding SS. UNF allegations of OTHER against SS's BF regarding SS.
3/25/14-UNF allegations of LS against SM regarding SS.
11/2/13-UNF allegations of IG, LS, PD/AM against SM regarding SS.
12/6/12-IND allegations of IG against SM and SS's BF regarding SS.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Required Action(s)

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

Issue:	Provision of Preventive services
Summary:	In May 2018, SaCDSS was aware SM did not have appropriate sleep provisions for SC, and SaCDSS did not provide such to the family. Instead, SaCDSS informed SM to have SC sleep in his car seat or the adult bed until provisions could be found/purchased.
Legal Reference:	423.4(d)
Action:	SaCDSS will provide information on sleep safety to the parents and caretakers of infants whom they encounter, and see that necessary steps are taken to provide safe sleeping conditions for the children in their care. SaCDSS will adhere to the OCFS-approved message regarding safe sleep practices when providing such education and provisions to families.

Preventive Services History

On 5/1/18, Saratoga County CPS attempted to open a preventive case to assist SM and SC with obtaining stable housing, Medicaid, and a "Pack 'n Play." Although some services were provided, this case never progressed to an FSS, and was closed ten days later upon receipt of the 5/11/18 SCR report.

A preventive mandated services case opened on 6/18/15 involving the now adopted male SS (born 5/22/15). This child was born with a positive toxicology for opiates, none of which SM was prescribed. This child was removed on 6/18/15 after SM was found to be under the influence and falling asleep while holding the child. This child was placed in foster care and in August 2016, both of his parents' (SM and this child's BF) parental rights were terminated due to abandonment. This child was freed for adoption in 2017.

Two preventive cases were opened in August and September 2006. Both cases were closed several days later. Neither case record had progress notes nor completed FASPs; it is noted the cases were opened to "pay a bill" and SM refused other services.

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

The SCR report was Indicated and closed on 7/24/18 by SaCDSS after receiving an email from SCDSS advising their case was to be indicated on SM and opened for services; therefore SaCDSS could indicate and close. SaCDSS recognized there was risk for the SC and explored with medical providers any initial concerns described in the SCR report. Throughout the investigation, they were unable to obtain medical documentation of ongoing safety concerns. SaCDSS caseworkers took a great deal of initiative to verify the SC was seen by medical providers. Although SM missed some appointments, the SC was seen five times in a six week period and doubled his weight between the first and last verified appointments. SM and SC relocated to Schenectady County on 6/20/18. At the request of SaCDSS, SCDSS conducted a home visit on 6/28/18 to discuss concerns with SM and remind SM of the need for her to go to mental health and substance abuse evaluations. Although approved safe sleep information was not provided on the home visit on May 1, it was provided on five occasions after, and a safe sleep environment was observed. There was ongoing, timely and appropriate communication between the districts documented in the case record. SaCDSS acknowledges that some casework was not documented in the case file, therefore causing concern that some actions were not taken.

Recommended Action(s)

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

Action:	OCFS' review of CPS history found that SaCDSS' investigation was ongoing at the time an SCR report with unrelated allegations was made regarding SM and SC in Schenectady County on 7/3/18, and SaCDSS' investigation remained open for 21 days into the SCDSS investigation. OCFS recommends SaCDSS revise or establish procedures surrounding communication between local districts when families change jurisdictions during open investigations. These procedures would be used to confirm the receiving county is appropriately apprised of all concerns and recommendations regarding the family prior to their move and case closure.

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