Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-17-007

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

Issue Date: Sep 14, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 9 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 03/30/2017
Initial Date OCFS Notified: 04/05/2017

Presenting Information

The 9-month-old female SC died in the hospital on 3/30/2017. She, her five SS, and BM were involved with Monroe County Department of Human Services (MCDHS) at the time. The SC was born premature and had never left the hospital in her lifetime. The SC had multiple medical complications from the premature birth. On 3/13/2017, the SC developed an infection and had a fever and seizures. She declined from there, developing multiple life-threatening conditions. Hospital staff witnessed the SC's death. MCDHS was made aware of the death, then notified OCFS via the appropriate 7065 Agency Reporting form.

Executive Summary

MCDHS learned of the death of the 9-month-old SC on 3/30/2017 from a collateral contact. At that time, MCDHS had an open long-term CPS services case with the family, as well as an ongoing CPS investigation that was initiated 12/4/2015 following the death of a 4-month-old sibling (the case had not yet been determined or closed). OCFS' Rochester Regional Office issued a child fatality report regarding the sibling on 5/31/2016, though a complete review of the investigation was unable to be documented, as the investigation was pending at the time of that writing.

Within 24 hours, MCDHS obtained information from the hospital where the SC had been the entirety of her life, as well as where she passed away. It was learned the SC suffered escalating medical conditions in the time leading up to her death. Hospital staff informed MCDHS an autopsy would only be completed at the BM's request. It was not documented whether an autopsy was completed.

At the time of the SC's premature birth, MCDHS had open CPS investigations, CPS services, foster care, and preventive cases. It was previously noted BM abused alcohol and illegal drugs on more than one occasion during her pregnancy with the SC. Three SS were removed the month before the SC's birth for ongoing concerns with BM, including but not limited to: poor/absent supervision, drug/alcohol misuse, untreated mental health issues, educational neglect, lack of appropriate food/clothing/shelter, and inadequate guardianship. One SS was returned to BM's care a few months prior to the SC's death, and another SS was returned shortly after the SC's death, both under the supervision of MCDHS. The other SS who had been removed remained with the non-relative caregiver under non-LDSS custody, until the scheduled final permanency hearing in August 2017. The goal for that child remained reunification with BM. Two other SS were involved in neglect proceedings but were never removed from BM as they were in the custody of their BF.

The therapist with the preventive agency continued to work with the family in therapeutic sessions to address the fatality as well as ongoing service needs. MCDHS continued to monitor the family through their open case.

This review resulted in a citation in the open CPS services case, as well as citations on historical cases relating to casework practice. In response, MCDHS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) MCDHS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, MCDHS 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?** N/A

Determination:

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

Explain:
The fatality was not reported to the SCR; therefore, there were no required safety assessments or determinations to be made pertaining to the fatality.

Was the decision to close the case appropriate? N/A

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:
As for the investigation (INV) that initiated on 12/4/2015, still open at the time of the SC's death on 3/30/2017, sufficient information was gathered to close that case prior to the date it was actually closed (30 months after the intake report). MCDHS did remain actively involved with the family during the whole time the INV was open. Though the INV closed, the case remained open for services.

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: 03/30/2017 **Time of Death:** 09:39 AM

Date of fatal incident, if different than date of death: 03/13/2017

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

County where fatality incident occurred: Monroe

Was 911 or local emergency number called? No

Did EMS to 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: Hosptialized

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Mother	No Role	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Other Household 1	Deceased Child	No Role	Female	9 Month(s)
Other Household 2	Father	No Role	Male	29 Year(s)
Other Household 2	Sibling	No Role	Male	5 Year(s)
Other Household 3	Other Adult - SS's BF	No Role	Male	37 Year(s)
Other Household 3	Sibling	No Role	Female	13 Year(s)
Other Household 3	Sibling	No Role	Male	10 Year(s)
Other Household 4	Other Adult - SS's Legal Guardian	No Role	Male	41 Year(s)
Other Household 4	Sibling	No Role	Female	12 Year(s)

LDSS Response

At the time of the SC's death on 3/30/2017, there was an open CPS investigation from an intake date of 12/4/2015, alleging IG and DOA/Fatality against BM regarding a sibling who died on that date. There was also an open CPS services case for long-term monitoring as well as continued involvement with preventive services, which documented information in the case record regarding the SC's death. The open CPS investigation noted no information regarding the death of the SC or any information regarding related activity in response to the fatality. The investigation was indicated and closed four days after the SC's death.

The SC was born prematurely, and it was noted in the record that BM was proven to have been abusing alcohol and illegal drugs during the pregnancy. The SC never left the hospital following her birth nine months prior.

The SC's death was not reported to the SCR as she had been hospitalized all her life for her medical issues; and, although the record does not reflect that the death was expected, medical staff responsible for her care did not note suspicions of abuse or maltreatment as it pertained to the SC's death. MCDHS began gathering facts and circumstances immediately upon learning of the SC's death, which occurred at Strong Memorial Hospital. MCDHS learned from hospital staff that although an autopsy report was unlikely, there were medical complications with the child that worsened two weeks prior to her death. Though the BM was contacted by the therapist with the preventive agency to discuss the death and offer

condolences, there was no note as to whether the BM was with the SC at the time of her passing. At the time of that contact, the BM was distraught over the death and expressed verbal frustration towards the eldest SS regarding a recent school suspension. The therapist continued efforts to process the death with the entire family through further therapeutic sessions at later dates.

MCDHS and the preventive therapist saw and spoke to all family members following the death of the SC. MCDHS continued to monitor the order of supervision pertaining to the two SS who were recently returned to the BM's care after having been removed nearly one year prior. The third SS who had been removed remained with her alternate caregiver, and further court hearings were scheduled to follow.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Although the fatality has not yet been reviewed, the Monroe County Child Fatality Review Team (CFRT) reviews all fatalities under Section 20 of Social Services Law. The plan is to review the fatality once the CFRT is notified.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
The CPS investigation that was open at the time of the fatality had late/missing safety assessments and many non-contemporaneous notes.

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?	☒	☐	☐	☐
Explain: Safety assessments of all SS were conducted by day 7 proceeding the SC's death. By day 30, all SS were seen and again notes were entered about their respective statuses of safety.				

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 RAP in the open investigation incorrectly reported no infant in the family unit (because SC was never added to the case, as was necessary).				

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:
Children remained with alternate caregivers under the supervision of MCDHS, as they were removed from BM prior to the fatality. They were removed for reasons unrelated to the death of the SC.

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☒	☐	☐	☐	☐	☐	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☒	☐	☐	☐	☐	☐	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Several services were recently completed by BM prior to the SC's death, such as parenting classes and alcohol/substance abuse treatment. MH treatment was ongoing, before and after the SC's death.

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:
Some siblings were already receiving therapeutic services for ongoing needs, including grief over the loss of the first deceased sibling. Services continued with those children, and were added for others in response to the second fatality regarding SC.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Services continued for BM, and continued to address grief over the loss of 2 of her children. It does not appear services were offered to the BF in response to the fatality, though he had never cared for the child and had questioned whether he was in fact the biological father.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
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?	Yes

Infants Under One Year Old

During pregnancy, mother:

- ☒ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Was not noted in the case record to have any of the issues listed
- ☒ Had heavy alcohol use
- ☐ Smoked tobacco
- ☒ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/30/2017	Sibling, Male, 10 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 10 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Female, 13	Mother, Female, 34	Parents Drug / Alcohol	Unfounded	

Years	Years	Misuse	
Sibling, Female, 13 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unfounded

Report Summary:
SCR report alleged when the 13 and 10-year-old SS (who lived with their BF) visited the BM, she abused alcohol in their presence. At times BM would sleep/"pass out" after drinking alcohol. Last year, BM provided the 10-year-old SS with alcohol and made him try it. BM was physically abusive towards the SS. BM hit the 10-year-old's shoulder with a bamboo stick and pulled the 13-year-old's hair. The SS did not feel safe going to the BM's home. The 12-year-old SS who was on previous cases was not named in this report since she lived with an alternate resource person and chose not to visit the BM.

Determination: Unfounded | **Date of Determination:** 02/25/2017

Basis for Determination:
Despite the 10-year-old SS making disclosures that the BM let him try alcohol, pulled the girls' hair, and hit them with a belt, MCDHS concluded there was no credible evidence to support the allegations. The 5-year-old SS reported he was hit with a belt by his mother, and showed CW a mark on his leg that he said he had recently sustained as a result. MCDHS then noted the reported information was regarding BM's behaviors prior to the report date, and stated since it was not ongoing, there was no basis to IND the report; however, there was in fact some credible evidence to Sub the allegations.

OCFS Review Results:
An incorrect determination was made regarding one of the allegations. It was documented there was no credible evidence, when in fact there was. More than one child disclosed inappropriate discipline; XCP was never added and the roles of one of the children who disclosed was not changed to reflect he was a victim child. A SS disclosed current inappropriate discipline, and MCDHS documented on the same date that the 24 hour safety assessment revealed, "all of the children deny any current safety concerns." MCDHS did however address the reported concerns with the family. SC, who remained in the hospital during this report but was still a member of the family unit, was never added to the report.

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

Issue:
Appropriateness of allegation determination

Summary:
An incorrect determination was made regarding some allegations, and XCP should have been added but was not. It was recorded that SS made no disclosures of maltreatment, when in fact they did, even though some were regarding past events. Another SS disclosed current inappropriate physical discipline, including an injury. MCDHS then concluded there was no credible evidence when in fact there was.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
MCDHS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/26/2016	Sibling, Male, 4 Years	Father, Male, 28 Years	Inadequate Guardianship	Indicated	No
	Sibling, Male, 4 Years	Father, Male, 28 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 11 Years	Father, Male, 28 Years	Educational Neglect	Indicated	
	Sibling, Male, 4 Years	Mother, Female, 33	Lack of Supervision	Indicated	

	Years		
Sibling, Female, 11 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 4 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 13 Years	Mother, Female, 33 Years	Educational Neglect	Indicated
Sibling, Female, 11 Years	Mother, Female, 33 Years	Educational Neglect	Indicated
Sibling, Female, 11 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Female, 11 Years	Father, Male, 28 Years	Inadequate Guardianship	Indicated
Sibling, Female, 11 Years	Father, Male, 28 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 13 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 4 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Female, 13 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 13 Years	Father, Male, 28 Years	Inadequate Guardianship	Indicated
Sibling, Female, 13 Years	Father, Male, 28 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 11 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated
Sibling, Female, 13 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated

Report Summary:
SCR report alleged on 3/25/16, BM was out of control and hit the 13-year-old SS excessively and kicked her out of the home. LE responded, and it was unknown if the SS sustained injuries. A subsequent report on 5/2/16 alleged BM abused alcohol daily while being the sole caretaker of 3 SS. BM was physically and verbally aggressive towards all children when intoxicated. 2 SS had excessive school absences as BM kept them home, thus they were failing. BF smoked marijuana in the SS's presence. Another subsequent report on 5/5/16 alleged BM took the eldest SS to an appointment while intoxicated and vomited in her presence, and left the other 2 SS home alone.

Determination: Indicated | **Date of Determination:** 12/20/2016

Basis for Determination:
MCDHS confirmed BM struck SS in the face with a closed fist. That night BM was also intoxicated and left the SS alone without supervision, and did not plan for SS's care when SS left the home. The 13 and 11-year-old SS were failing school because of absences, as BM made them stay home. BM left the SS without supervision again when she went to the hospital – a protective removal ensued. BM tested positive for cocaine and admitted to alcohol use, both on more than one occasion during pregnancy. SC was born during the investigation and remained hospitalized for medical complications related to premature birth. SC remained in BM's custody. There was no evidence of PD/AM against BF.

OCFS Review Results:
4 months after she was born, MCDHS added the SC to the case, who was born 3 months into this investigation. MCDHS

completed all casework activity with accurate assessments and timely documentation, and responded to all arising concerns in an appropriate manner. MCDHS worked to involve parents and family members and utilized resources for the children when they came into care. MCDHS corresponded with the Preventive worker and other service providers. MCDHS took appropriate actions to protect the children by removing them and filing a neglect petition against BM.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/04/2015	Sibling, Male, 4 Months	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Male, 4 Months	Mother, Female, 33 Years	DOA / Fatality	Indicated	

Report Summary:
SCR report concerned the death of a 4-month-old SS, found unresponsive on a mattress where he had been placed to sleep with a 4-year-old SS. BM had placed him there to sleep and the next morning he was found by a 10-year-old SS to be cold and unresponsive with blood coming from his nose and mouth. BM contacted EMS. The SS was pronounced deceased at 9:45 am on 12/4/15. The roles of the SS, ages 4, 10, and 13, as well as the deceased child's BF, were unknown.

Determination: Indicated **Date of Determination:** 04/01/2017

Basis for Determination:
BM told MCDHS and LE that she placed the infant in a bed with 3 other SS that also contained blankets and pillows. She relied on the SS to provide care for the infant during the night. MCDHS determined BM placed the infant in an unsafe sleeping environment which ultimately put him in immediate danger of serious harm. The allegation of IG was appropriately Sub. DOA/Fatality was appropriately Unsub as the ME pronounced the infant's cause and manner of death as undetermined and there was no confirmed causal connection between the maltreatment and the cause of death.

OCFS Review Results:
Although actions regarding placement of the children when concerns arose were appropriate, there were several citations pertaining to timely/adequate assessments of safety/risk and progress notes, timeliness of determination, and an instance of a child being born during the open investigation (SC) who was never added to the report. Sufficient information was obtained to determine and close the investigation in an appropriate amount of time, though the investigation remained open for 30 months.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
No 7-day safety assessment was completed.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
MCDHS will complete all safety assessments, and in the amount of time required.

Issue:
Timely/Adequate 24 Hour Assessment
Summary:
The 24-hour safety assessment required in this fatality investigation was completed 5 days late.
Legal Reference:
SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:

MCDHS will complete all safety assessments, and in the amount of time required.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
More than 20 progress notes were entered non-contemporaneously to their event dates, several being entered 1-2 years later. There were also progress notes missing regarding changes in placement of the children as well as related legal activity.
Legal Reference:
18 NYCRR 428.5
Action:
All progress notes will be entered contemporaneously to their event date. Notes will reflect key information pertaining to case circumstances.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP incorrectly reported there was no infant in the family unit. This was because SC was never added to the case, as was necessary.
Legal Reference:
18 NYCRR 432.2(d)
Action:
MCDHS will consider all risk elements identified throughout the course of the investigation and accurately document such elements in the Risk Assessment Profile.

Issue:
A child was born during an open CPS investigation and never added to the report
Summary:
The SC was born during this investigation and was never added to this report. Documentation consistently noted the expectation that the SC would return home once medically ready.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(e)
Action:
MCDHS is required to obtain the name, age, and condition of other children in the home. MCDHS will add all appropriate household members to open investigations. The family unit is defined to include any child who is temporarily in another living situation but who is expected to return home and subject to an assessment of risk.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
New information and evidence became apparent during the open case regarding the allegation of EdN for the school-aged SS in BM's care but allegations were not added/substantiated.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
MCDHS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Issue:
Timeliness of Determination
Summary:

This investigation was open at the time of the SC's death and was determined 30 months after the report's intake date.

Legal Reference:

SSL 424(7);18 NYCRR 432.2(b)(3)(iv)

Action:

The child protective service has the sole responsibility for making a determination within 60 days after receiving the report as to whether there is some credible evidence of child abuse and/or maltreatment so as either to "indicate" or "unfound" a report of child abuse and/or maltreatment. There was sufficient information to determine the report well before the 30 months in which it was done.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/10/2015	Sibling, Female, 11 Years	Other Adult - SS's BF, Male, 35 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	Sibling, Female, 11 Years	Other Adult - SS's BF, Male, 35 Years	Inadequate Guardianship	Unfounded	

Report Summary:

SCR report alleged SS's BF severely restricted the 12-year-old SS's diet, only allowing her small amounts of food. The SS allegedly went hungry and cried for food.

Determination: Unfounded | **Date of Determination:** 07/07/2015

Basis for Determination:

MCDHS interviewed the 12-year-old SS and her BF, and both denied she was restricted from meals. Both confirmed her snacks were restricted due to the SS being overweight. BM confirmed the child was not underweight. MCDHS found no other safety concerns regarding the two SS who primarily resided with this father during the investigation.

OCFS Review Results:

MCDHS interviewed the 2 SS listed on the report as well the rest of BM's children. MCDHS made an adequate assessment of the allegations and appropriately UNF the report. MCDHS made diligent efforts to assess 24-hour safety, but when no contact was able to be made, there were no further attempts to address the report for two weeks. MCDHS did not adequately address with BM new disclosures from the children regarding physical discipline and DV. The 7-day safety assessment was 9 days late and the question regarding history of alcohol misuse affecting caretaking abilities was incorrectly scored on the RAP.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP indicated BM had no history within 2 years regarding alcohol use impacting her care, despite an indicated report concerning such within the 2 years prior.

Legal Reference:

18 NYCRR 432.2(d)

Action:

MCDHS will take into account all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day safety assessment was 9 days late.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
MCDHS will complete all safety assessments in the amount of time required.

Issue:
Determination of Nature, Extent and Cause of Conditions (Report)
Summary:
When 2 SS disclosed physical discipline with a belt, BM was not questioned; however, the children reported no injuries as a result and could not definitively say when this occurred. 1 SS disclosed a DV incident between parents in his presence. Although this was addressed with his BF and he denied, BM was never questioned about such.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(d)
Action:
In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. MCDHS 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)	Status/Outcome	Compliance Issue(s)
01/23/2015	Sibling, Female, 10 Years	Mother, Female, 32 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Female, 12 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 3 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 3 Years	Mother, Female, 32 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 10 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 12 Years	Mother, Female, 32 Years	Educational Neglect	Indicated	
	Sibling, Female, 12 Years	Mother, Female, 32 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 10 Years	Mother, Female, 32 Years	Educational Neglect	Indicated	

Report Summary:
SCR report alleged the 12-year-old SS missed 47 days of school and had a history of poor attendance. The SS was failing several subjects as a result. Despite BM being contacted by phone, letter, and home visit, the SS continued to miss school. BM kept the SS home to care for her siblings. A subsequent report dated 3/5/15 was consolidated with the initial report, and alleged BM placed the 3 SS at risk of harm when she attempted suicide by way of ingesting antidepressants.

Determination: Indicated | **Date of Determination:** 07/01/2015

Basis for Determination:
The 12 and 10-year-old SS had excessive absences which affected their grades, without reasonable explanation. MCDHS appropriately added and Sub the allegation of EdN against BM regarding the 10-year-old SS. The father on their birth certificate (SS's BF) was historically a person legally responsible and previously claimed them as his children; however,

he was not asked about his involvement in their care. Therefore, he should have been involved in conversations regarding concerns for those children. Although the BM admitted to attempted suicide, there was an adult in the home and the SS had little to no knowledge of the extent of the event and did not appear negatively impacted.

OCFS Review Results:
MCDHS corresponded with the Preventive Services worker to address the concerns and exchange information about the family's progress. MCDHS did not adequately address new disclosures from the children with BM regarding physical discipline and DV or concerns about EdN with the SS's BF. The 7-day safety assessment was 3 days late and the question regarding history of alcohol misuse effecting caretaking abilities was incorrectly scored on the RAP.

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

Issue:
Determination of Nature, Extent and Cause of Conditions (Report)
Summary:
When 2 SS disclosed physical discipline with a belt, BM was not questioned. 1 SS disclosed a DV incident between parents in his presence. This was addressed with his BF and he denied; it was not addressed with BM. The SS's BF was not included in discussions about concerns regarding EdN, despite being contacted and on their birth certificate as the father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(d)
Action:
In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. MCDHS 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.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP indicated BM had no history within 2 years regarding alcohol use impacting her care, despite an indicated report concerning such within the 2 years prior. The RAP further identified that BM had not prioritized her own needs above those of her children, yet the case record showed she regularly kept the children home from school to help her.
Legal Reference:
18 NYCRR 432.2(d)
Action:
MCDHS will take into account all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day safety assessment was 3 days late.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
MCDHS will complete all safety assessments in the amount of time required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/06/2014	Sibling, Female, 9	Mother, Female, 31	Inadequate Food / Clothing /	Unfounded	Yes

Years	Years	Shelter	
Sibling, Male, 2 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 11 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unfounded
Sibling, Female, 9 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unfounded
Sibling, Male, 2 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unfounded
Sibling, Male, 2 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unfounded
Sibling, Female, 11 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 11 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unfounded
Sibling, Female, 9 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unfounded

Report Summary:
SCR report alleged BM was addicted to crack cocaine and was unable to provide a minimal degree of care for 3 SS, ages 11, 9, and 2. BM was selling drugs from the home, exposing the SS to questionable traffic. BM sold her food stamps to support her drug habit. There was no food in the home, nor were there diapers or wipes for the baby. BM allowed an uncle, a registered sex offender, to frequent the home and have contact with the 11-year-old SS whom he had sexually abused in the past.

Determination: Unfounded | **Date of Determination:** 07/01/2014

Basis for Determination:
After conducting unannounced visits and interviews, MCDHS found no evidence of drug misuse by BM, nor any drug traffic at the home. Although food supply was often minimal, BM obtained food in times of need from pantries, relatives, and assistance from MCDHS. The youngest SS was toilet-trained and thus no child required diapers or wipes. MCDHS confirmed the uncle mentioned in the report was a registered sex offender, but found no evidence that he frequented the home.

OCFS Review Results:
MCDHS adequately addressed all allegations and responded to additional concerns as they arose, such as the children's attendance and the possibility of BM's alcohol misuse. When MCDHS followed up, both additional concerns lacked evidence to add or substantiate new allegations. Near the end of the case, when food supply was extremely low, MCDHS noted they would return with a food voucher for BM but never documented whether this was completed; the case was closed shortly thereafter. The 7-day safety assessment was 13 days late. MCDHS appropriately offered and referred the family for Preventive Services upon closing the investigation.

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 13 days late.

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

Action:
MCDHS will complete all safety assessments in the amount of time required.

[redacted]

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

2/18/08-3/19/08 UNF against BM regarding 4 SS. Allegations included CD/A, IF/C/S, IG, LM, LS, & PD/AM.

8/11/08-12/26/08 UNF against BM & BF1 for IG & LM re: 21-month-old SS.

2/20/10-6/2/10 UNF against BM & a parent substitute (PS) for IG, IF/C/S, & PD/AM re: 3 SS. One SS had no role.

5/1/10-6/2/10 UNF against a PS for IG & PD/AM re: 3 SS. One SS was not added to the case.

6/10/10-8/25/10 IND against BM for IG & PD/AM re: 4 SS; Unsub for LM re: a SS alleged in a subsequent report on 6/16/10. SS's BF was also IND for IG of 4 SS.

10/26/10-1/11/11 IND against BM & SS's BF. Allegations of IG & PD/AM were Sub against BM re: 3 SS. Allegation of IG was Sub against SS's BF re: 3 SS. Unsub allegations were IG & PD/AM against BM and SS's BF re: one SS, and PD/AM against SS's BF re: the other 3 SS. A subsequent report on 12/2/10 had similar concerns and was consolidated into this report.

12/1/10-1/11/11 UNF against BF & a PS for IG, PD/AM, & L/B/W re: 2 SS.

2/17/11-4/14/11 UNF against BM & SS's BF for IG re: a SS.

6/21/11-7/22/11 UNF against BF for IG & LS re: a SS.

10/29/12-1/3/13 UNF against BM re: 4 SS. Allegations included CD/A, EdN, IG, LS, & PD/AM. A subsequent report on 11/19/12 was consolidated into this report.

1/31/13-3/28/13 UNF against BM for IG, LS, & PD/AM re: 2 SS.

6/3/13-7/15/13 IND against BM for IG, LS, & PD/AM re: a SS.

10/29/13-1/3/14 UNF against BM for EdN & IG re: a SS.

4/29/13-6/29/13 IND against BM for IG & L/B/W re: her 1-year-old nephew.

Known CPS History Outside of NYS

There is no known CPS History outside of New York State.

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: 08/04/2014

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: 08/04/2014

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
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?	☒	☐	☐	☐
If yes, was the response appropriate to the circumstances?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

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: In addition to LDSS monitoring, contracted agencies were involved as well.				

Required Action(s)

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

Issue:	Timeliness of completion of FASP
Summary:	A plan amendment was not completed following the fatality. The purpose of a plan amendment is to describe/document significant changes in the status of a case and direct a reassessment so that any necessary revisions to the service plan can be made.
Legal Reference:	18 NYCRR428.3(f)
Action:	MCDHS will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Preventive Services History

A voluntary Preventive case opened 12/14/12 which included BM and 3 SS. 2 SS were not on the services case as they were residing with their BF. Issues addressed were BM's MH and alcohol abuse, and the need for a SS to have specific services. Although the SS completed therapy, the BM did not ensure SS received the necessary continued therapies. Engagement in recommended services for BM was never accomplished. The case was closed 1/9/14 due to lack of contact.

A voluntary Preventive case opened 8/4/14 due to BM's Hx of struggling to meet the basic needs of the family. There were ongoing concerns with finances, SS's school attendance, and lack of follow-through on needed services for the SS and BM. BM's alcohol misuse was a continued safety concern, which worsened upon the death of the infant SS that occurred 12/4/15. More intense, trauma-based services were implemented following the SS's death. A protective removal ensued on 5/4/16, and at that time a Protective Program Choice was added. SC was born prematurely during this case, and concerns were revealed regarding BM's drug and alcohol use during pregnancy. The Preventive case with one agency closed in November 2016 as BM had met her goals with parenting classes, substance abuse Tx, and continued MH Tx. Long-term CPS monitoring remained open and in place, as SS were still in non-LDSS custody under the supervision of MCDHS.

Casework Contacts

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

Required Action(s)

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

Foster Care Placement History

On 5/4/16, MCDHS placed 3 SS (then ages 4, 10 and 13) in foster care per a protective removal (consent). The 10-year-old SS was found home alone and it was determined she had been caring for the 4-year-old SS in BM's absence for approximately 24 hours with little to no food. BM was admitted to the hospital for pregnancy complications and did not plan for their care. Upon arrival to the hospital she smelled heavily of alcohol and was vomiting. She also tested positive for cocaine. There were ongoing concerns for BM's worsening alcohol abuse in addition to her aggression towards the children. It was found that the SS had poor school attendance as BM would keep them home for unknown reasons. The two younger SS were later placed in direct relative placement, while the 13-year-old SS was ordered to remain in foster care due to her Person in Need of Supervision (PINS) status. She went to live with her BF 3 months later. The children were adjudicated neglected by BM in Family Court. BM graduated her parenting and substance abuse classes, and was engaged in MH services. BM was then granted unsupervised visits with the children, and the eldest SS was ordered to return to BM's care and custody under the supervision of MCDHS. Shortly after that, so was the youngest. The other SS who had been removed remained with alternate caregiver until the Date Certain, scheduled for August 2017.

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	Return to Parent
Respondent:	038884 Mother Female 34 Year(s)	
Comments:	Of BM's seven children, three SS were removed on 5/4/16 per BM's consent (SC was not born; one SS was predeceased; two SS resided with their BF). Neglect was filed against BM regarding the 6 SS, which included the deceased SS. BM was adjudicated for neglect of the six SS on 9/28/2016 and the three SS remained in foster care/alternate placement locations. On 2/2/17 the eldest SS was released to the care of BM under the supervision of MCDHS. The same occurred with the youngest SS on 6/1/17. On 2/2/17 the other SS in care was ordered to remain with her alternate caregiver under the supervision of MCDHS until the next permanency hearing, the Date Certain. The SC was never involved in any Family Court 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