Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-21-024

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

Issue Date: Mar 29, 2022

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 10/19/2021
Initial Date OCFS Notified: 10/19/2021

Presenting Information

Two SCR reports were received that alleged on 10/16/21, at approximately 9:00 AM, the 1-year-old subject child was having difficulty breathing. Sometime prior to 11:48 AM, the daycare provider that was caring for the child called the mother and the grandmother to inform them of the concerns. The grandmother went to the daycare provider's home and it was unknown if the mother responded. Medical care was delayed as emergency services were not called by the mother or grandmother. Instead, the grandmother attempted CPR with no success. The grandmother then transported the child to the hospital. The child was pronounced dead as the result of an anoxic brain injury. The child had opiates in her blood stream which contributed to her death. The opiates were accessible to the child in the home of one or more of the adults. The roles of the 6 and 5-year-old siblings and the father were unknown.

Executive Summary

On 10/19/21, the Monroe County Department of Human Services (MCDHS) received two SCR reports regarding the death of the 1-year-old female subject child that occurred on that date. A familial SCR report was received with the allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Medical Care against the mother and maternal grandmother and a daycare SCR report was received that contained the same allegations against the day care provider. MCDHS had an open CPS investigation at the time, which was received on 10/17/21, following an incident that occurred at the daycare provider's home on 10/16/21, that led to the child's death. The child resided with her mother and two siblings, ages 6 and 5. The father of the children was incarcerated for unrelated charges. The children were cared for on a regular basis by a licensed home daycare provider and there were no other children residing in the daycare provider's home or in her care.

Upon investigation it was learned that the daycare provider cared for the children overnight on 10/15/21. The child slept in a portable crib in the living room and the siblings slept on the couch. When the daycare provider checked on the child around 10:30 AM, she noticed the child was having difficulty breathing. The daycare provider called the mother, and the mother contacted the maternal grandmother, who went to the provider's home. When the grandparents arrived, the grandmother called 911 and performed CPR while the grandfather picked up the mother. When the grandfather and mother returned to the provider's home, they transported the child to a nearby urgent care. Life saving measures were performed and the child was transported by ambulance to the hospital. The child was placed on life support until 10/19/21, at which time care was withdrawn since it was determined the child had no brain activity. The child was declared deceased at 1:17 AM on that date.

An autopsy was performed, and the final report had not been received at the time this report was written. The law enforcement investigation remained open pending the final autopsy results.

Hospital records showed the child arrived at urgent care with no pulse. She regained a pulse following the administration of CPR and she was transferred to the hospital. Hospital staff reported that the child had no underlying medical condition or illness. The child's toxicology test was positive for opiates, which was not attributed to the medication she received during resuscitation efforts. The child suffered an anoxic brain injury due to a lack of oxygen when she stopped breathing, which resulted in her death.

The mother and daycare provider denied substance use and both homes were assessed to be free from drugs. The daycare provider reported that her brother had recently been living with her and he was receiving Hospice care until he passed

away. He was on a significant amount of medication, including opiates. The daycare provider said she had previously found pills around the home despite cleaning the home several times since his death. Medical providers determined if the child had ingested one of the daycare provider's brother's pills it would have resulted in a positive toxicology and the resulting anoxic brain injury.

The Child Care Council investigated, and there were no citations for the daycare. The daycare provider was not watching any other children at the time the case closed and the mother was no longer utilizing the provider as a resource for the siblings. The family was referred for trauma services and a Preventive Services Case opened on 12/22/21. The familial and daycare cases were unfounded based on a lack of credible evidence since the mother, grandmother and daycare provider sought medical attention in a timely manner, and it was believed the child may have found a pill in the daycare provider's home that the provider was not aware of and ingested it, resulting in the child's death.

PIP Requirement

MCDHS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the MCDHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDHS 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?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:

The case was appropriately unfounded and opened for Preventive Services.

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:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	A 30-Day Safety Assessment was not documented and approved in Connections.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	A safety assessment will be documented and approved by a supervisor within 30 days of a report if such report contains the allegation of DOA/Fatality, as required.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/19/2021 **Time of Death:** 01:17 AM

Date of fatal incident, if different than date of death: 10/16/2021
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? Yes
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
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:
☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **In the same room**

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Other Household 1	Father	No Role	Male	28 Year(s)
Other Household 2	Day Care Provider	Alleged Perpetrator	Female	64 Year(s)
Other Household 3	Grandparent	Alleged Perpetrator	Female	47 Year(s)

LDSS Response

MCDHS spoke to the sources of the reports, law enforcement, hospital staff, school staff, the daycare provider's physician, and the Child Care Council. They reviewed SCR history, and EMS, hospital, and OB/GYN records. MCDHS assessed the mother's and daycare provider's homes to be safe, and they interviewed the mother, siblings, grandparents and the daycare provider.

The mother reported that the daycare provider often watched the children overnight and she never had any concerns. The subject child was healthy other than she snored, and she took allergy medication. The mother denied that she used any illegal drugs or opiates, and she denied knowing why the child's toxicology was positive for opiates. On the night of 10/15/21, she and a friend picked the child up after getting her hair done around 8:00 PM. They stopped at a store with the child, and she was acting normal and happy at that time. They dropped the child off at the daycare provider's home around 9:45 PM and the siblings were already there.

The mother said she texted the daycare provider at 10:27 AM on 10/16/21, and told her she and the grandmother would be picking up the children soon. The daycare provider responded "OK". About 30 minutes later the provider called her and said to come right away because the child was not breathing right. The mother told the provider not to call 911 until she got there, because it didn't seem urgent. The mother called the grandmother and asked her to come and pick her up. The grandparents drove directly to the provider's home, then the grandfather picked the mother up while the grandmother called 911 and waited for the ambulance to arrive. When the mother and grandfather arrived, the grandmother was giving the child CPR. The mother picked up the child and ran to the car. The child gasped and turned purple, so they brought the child to the nearest medical facility.

The siblings reported that the subject child slept in a portable crib at the daycare provider's home, and they slept on the couch. They said they woke up and asked the daycare provider what was wrong, and she told them the child couldn't breathe so the mother took the child to the doctor. The siblings did not provide any additional details about the incident.

The daycare provider said the siblings were dropped off at her home, then the subject child was dropped off around 11:00 PM. She gave the child a teaspoon of allergy medication that the mother provided. The child appeared to be tired. She walked around the apartment and played for a little while before going to sleep in the portable crib. The child was snoring when the daycare provider laid her down, which was typical. She slept in the living room with the children, and she heard the child wake up whining around 2:00 AM and 4:00 AM but the child quickly fell back asleep. Around 8:00 AM, the child was sleeping and breathing loudly. Around 10:00 AM the mother called and said she was coming to get the children soon, so the daycare provider tried to wake the child up. She called the mother when the child did not wake up. The mother told her not to call 911 until she got there. She gave the child a few rescue breaths, mucus came out and then the child sounded better. The grandmother called 911 when she arrived, which the provider said was about an hour after she tried to wake the child up. The provider denied that she had any opiates in her home since her brother passed away.

The grandmother said she drove to the daycare provider's home after the mother called and told her the child was not breathing right. She started performing CPR and called 911 because the child stopped breathing. The mother and grandfather arrived shortly after and they quickly drove the child to the nearest urgent care.

The father was interviewed in jail, and he reported no concerns for the mother's care of the children. He had no direct knowledge of the incident and he did not know the daycare provider.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: The case was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059841 - Deceased Child, Female, 1 Yrs	059842 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
059841 - Deceased Child, Female, 1 Yrs	059842 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
059841 - Deceased Child, Female, 1 Yrs	059842 - Mother, Female, 26 Year(s)	Lack of Medical Care	Unsubstantiated
059841 - Deceased Child, Female, 1 Yrs	059846 - Day Care Provider, Female, 64 Year(s)	DOA / Fatality	Unsubstantiated
059841 - Deceased Child, Female, 1 Yrs	059846 - Day Care Provider, Female, 64 Year(s)	Inadequate Guardianship	Unsubstantiated
059841 - Deceased Child, Female, 1 Yrs	059846 - Day Care Provider, Female, 64 Year(s)	Lack of Medical Care	Unsubstantiated
059841 - Deceased Child, Female, 1 Yrs	059847 - Grandparent, Female, 47 Year(s)	DOA / Fatality	Unsubstantiated
059841 - Deceased Child, Female, 1 Yrs	059847 - Grandparent, Female, 47 Year(s)	Inadequate Guardianship	Unsubstantiated
059841 - Deceased Child, Female, 1 Yrs	059847 - Grandparent, Female, 47 Year(s)	Lack of Medical Care	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine

All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☒	☐	☐
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:
Attempts to contact the Medical Examiner were not documented.

Fatality Safety Assessment Activities

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

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

Explain:
The safety of the siblings was adequately assessed; however, a 30-Day Safety Assessment was not documented and approved in Connections.

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 family was referred to and accepted trauma services related to the fatality.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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:
The siblings were provided with trauma services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were provided with trauma services.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/17/2021	Deceased Child, Female, 1 Years	Day Care Provider, Female, 64 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 1 Years	Day Care Provider, Female, 64 Years	Internal Injuries	Unsubstantiated	

Deceased Child, Female, 1 Years	Day Care Provider, Female, 64 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
An SCR report alleged that on 10/16/21, while in the care of the daycare provider, the subject child began having difficulty breathing. The daycare provider did not call emergency services but instead contacted the mother. The mother called the grandmother who went to pick up the child from the daycare. The grandmother called emergency services, performed CPR on the child while waiting for the ambulance, and then drove the child to the hospital because the ambulance did not respond quickly enough. The child stopped breathing when they arrived at the hospital. The child suffered a severe anoxic brain injury from a lack of oxygen. The child had no known medical condition and she was healthy.

Report Determination: Unfounded **Date of Determination:** 12/13/2021

Basis for Determination:
The daycare provider discovered the child's breathing was labored when she checked on the child. She said the child was acting normally the night prior when the child was placed to sleep in a portable crib. The daycare provider immediately notified the mother, who contacted the grandmother since she could get to the home more quickly. The child received emergency medical care and she passed away two days later. Toxicology tests showed the child was positive for opiates. The daycare provider denied opiate use and reported her brother recently passed away and the child may have ingested one of her brother's pills that may have fallen on the floor. The Child Care Council found no citations.

OCFS Review Results:
MCDHS conducted home visits at the mother's and daycare provider's homes and they assessed both homes to be safe. They interviewed the mother, father, siblings, grandmother and daycare provider. Safety Assessments and the RAP were completed timely and accurately. The case record did not reflect that Notice of Existence was provided to the required adults. Relevant collaterals were contacted.

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

Issue:
Failure to provide notice of report

Summary:
The case record did not reflect that Notice of Existence was provided to the required adults.

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

Action:
MCDHS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/01/2019	Sibling, Male, 4 Years	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 4 Years	Mother, Female, 24 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 3 Years	Mother, Female, 24 Years	Lack of Supervision	Substantiated	
	Other Child - Other Adult 1's Child , Female, 1 Years	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	

	Other Child - Other Adult 1's Child , Female, 1 Years	Mother, Female, 24 Years	Lack of Supervision	Substantiated

Report Summary:
An SCR report alleged that on 10/1/19, the mother was not supervising the two siblings, ages 4 and 3 at that time, and another child, aged 1, while they were outside. The 1-year-old child walked down the front porch stairs and into the busy street. The siblings were walking down the porch stairs approaching the street. All three children were outside for over five minutes without competent adult supervision.

Report Determination: Indicated | **Date of Determination:** 01/27/2020

Basis for Determination:
The mother was caring for the two siblings and a 1-year-old child that resided in the home at that time. She left the siblings unsupervised and playing in the front yard while she went upstairs in the home. The 1-year-old child exited the home through the open front door and went into the street. A person driving by stopped their car and brought the children up to the front door. The siblings went to get the mother and it took her approximately five minutes to come to the door. During the investigation the condition of the home deteriorated and the mother and siblings moved out. At case closing, the mother was residing with friends and the siblings were residing with the father.

OCFS Review Results:
MCDHS conducted home visits and they interviewed the mother, father, siblings, the other children and adults that resided in the home, and the fathers of the other children. Safety Assessments and the RAP were completed timely and accurately. Relevant collaterals were contacted, including school staff and the children's pediatrician. The case record reflected that Notice of Existence letters were generated in Connections late on 10/17/19. The mother agreed to work with preventive services to assist her with obtaining housing, but a Preventive Services Case was not opened. Ten out of 36 progress notes were entered more than 30 days past their event dates.

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

Issue:
Failure to provide notice of report
Summary:
The case record reflected that Notice of Existence letters were generated in Connections 9 days late on 10/17/19.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
MCDHS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Ten out of 36 progress notes were entered more than 30 days past their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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