Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-22-010

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

Issue Date: Oct 13, 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 8 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 04/23/2022
Initial Date OCFS Notified: 04/23/2022

Presenting Information

Two subsequent reports were received on 4/23/22 that alleged at approximately 2:00 AM, the father checked on the subject child while she was asleep on a medical bed in the living room of the home. The mother checked on the child again at 7:00 AM and she appeared well and to be asleep. At approximately 9:18 AM, the mother found the subject child unresponsive, immediately called 911 and attempted CPR. First responders arrived at the home, continued CPR and the child was transported to the hospital and pronounced deceased at 9:55 AM. The mother and the father did not have an explanation for the subject child's death, and it was unknown if her death was related to a medical condition.

Executive Summary

On 4/23/22, Monroe County Department of Human Services (MCDHS) received two SCR reports regarding the death of the 8-year-old female subject child during an open CPS investigation. There was an open CPS investigation with concerns the mother was not attending to the medical needs of the subject child and her 11-year-old sibling. At the time of the subject child's death, she resided with her mother and two siblings, ages 11-years-old and 9-months-old. The father did not reside in the home and had three other children, ages 14, 14, and 9-years-old. These children did not reside with the father or have regular contact with the subject child or surviving siblings.

MCDHS conducted a joint investigation with law enforcement, and they learned that the subject child had a complex medical history, multiple developmental disabilities, a g-tube for her feedings, and she had been sick with a runny nose and low-grade fever for the past week. The mother reported she had checked on the subject child the morning of 4/23/22, and went back to sleep for about 2 hours. When the mother awoke and checked on the subject child again, she was nonresponsive. The mother called 911 and attempted CPR. First responders arrived and transported the subject child to the hospital where she was pronounced dead. The 11-year-old sibling was at the maternal grandmother's home at the time of the death.

MCDHS assessed the safety of the 11-year-old and 9-month-old surviving siblings. It was determined due to the condition of the home and the uncertain circumstances around the death, a safety plan would be necessary, and the siblings were temporarily cared for by the maternal grandmother. MCDHS conducted a home visit with law enforcement at the residence. The home was minimally furnished and had a strong odor of urine and mildew. There were no appropriate sleeping arrangements for the 9-month-old sibling. Safe sleep guidance was provided to the mother and maternal grandmother. MCDHS provided the mother with a portable crib.

The father was interviewed by MCDHS; however, the record did not reflect that he was asked about being in the home during the events that led to the fatality. The father reported no concerns regarding the mother's parenting of the subject child and the surviving siblings. The surviving siblings were assessed safe in the care of the mother and maternal grandmother. MCDHS assessed the safety of the 14,14, and 9-year-old siblings and determined they were safe in the care of their guardians.

An autopsy was performed, though the final report had not been completed at the time of this writing. MCDHS spoke with the medical examiner, and the preliminary autopsy report listed the immediate cause of death as complications of neuroaxonal dystrophy. It was later learned that at her time of death, the subject child had tested positive for a virus.

MCDHS unsubstantiated the allegations of DOA/Fatality against the mother and DOA/Fatality and IG against the father.

MCDHS determined there was no evidence that supported the subject child's death was a result of abuse or maltreatment. The record did not reflect the subject child's lack of medical care (LMC) contributed to her death at the time the investigation closed. MCDHS indicated the mother for LMC and IG as she was a medically fragile child with medical needs that required appropriate monitoring and compliance with attending appointments and providing medications as prescribed. Preventive services were offered to the family and accepted, however, the family never engaged, and the case was closed as a result. The surviving siblings remained in the care of the mother at the close of the investigation and the family was referred to community-based services.

PIP Requirement

MCDHS will submit a PIP to the Rochester Regional Office within 30 days of the 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:

MCDHS made an appropriate determination based on the evidence obtained throughout the investigation.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:

Although all other casework activity was commensurate with case circumstances, the subject father was not interviewed regarding the allegations.

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

Issue:	Failure to Provide Notice of Indication
Summary:	The record did not reflect that MCDHS provided notice of indication letters to the adults on the report.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	MCDHS shall deliver or mail to the subject(s) and other persons named in the indicated report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.
Issue:	Assessment as to need for Family Court Action
Summary:	Concerns were identified regarding the 11yo and 9-month-old SSs medical needs. The mother had a history of not following through with medical appointments and declined services. The record did not reflect a consultation with MCDHS' legal department.
Legal Reference:	SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)
Action:	MCDHS 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/23/2022 **Time of Death:** 09:55 AM

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 09:27 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

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	8 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Month(s)
Other Household 1	Father	Alleged Perpetrator	Male	30 Year(s)

LDSS Response

MCDHS conducted a timely investigation into the subject child's death. They spoke to the source of the reports, medical examiner, school staff and medical providers. MCDHS searched history, notified the DA's office about the subject child's death, and conducted home visits.

The subject child had complex medical needs. The mother was interviewed and reported on the morning of the subject child's death, she checked on the subject child around 7:00 AM and she appeared fine. The mother went back to sleep and when she woke up again at 9:00 AM, she checked on the subject child and found her unresponsive. The mother called 911 and attempted CPR. First responders arrived at the residence, continued resuscitative efforts, and transported the subject child to the hospital, where she was pronounced dead. MCDHS followed up with Emergency Medical Services and hospital staff regarding the subject child. The subject child had a fever of 102 degrees upon arrival to the hospital and there were no obvious signs of trauma.

The mother reported that the subject child had been sick for about a week with a low-grade fever and a runny nose prior to her death. There was an open CPS investigation at the time of the fatality with concerns the subject child was missing medical appointments and not being provided with her medication. MCDHS followed up with collateral contacts that reported concerns for the subject child missing medical appointments and not receiving mediation as prescribed. The mother acknowledged to a medical provider she was not giving the subject child her medications as they were prescribed. The subject child required a suction machine, which she never received due to the cancellation of the order after unsuccessful attempts to contact the mother to schedule delivery. The school reported the subject child had ran out of medication and they made several attempts to reach out and assist the mother with getting the medications. Attempts to assist the mother were unsuccessful and the subject child went without medication at school for eight days.

There were also concerns identified in the open CPS investigation regarding the 11-year-old surviving sibling not receiving needed medical care. These concerns were not addressed in the open CPS investigation or the fatality investigation. MCDHS did not confirm with medical collaterals that the sibling's medical needs were being met by the mother. The mother was initially receptive to preventive services; however, later refused to participate. Despite this information, the record did not reflect a consultation with MCDHS' legal department.

The mother and the surviving siblings were offered services and a referral was made. The preventive services agency was unable to reach the mother and the case was closed. MCDHS found no safety concerns regarding the surviving siblings being with the mother and the safety plan was lifted. At the close of the investigation the mother and surviving siblings were residing with the maternal grandmother; the mother reported it was too difficult for the family to return to the home after the death of the subject child. MCDHS indicated and closed the report.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061165 - Deceased Child, Female, 8 Yrs	061166 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
061165 - Deceased Child, Female, 8 Yrs	061166 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
061165 - Deceased Child, Female, 8 Yrs	061166 - Mother, Female, 30 Year(s)	Lack of Medical Care	Substantiated
061165 - Deceased Child, Female, 8 Yrs	061169 - Father, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
061165 - Deceased Child, Female, 8 Yrs	061169 - Father, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

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

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine

Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

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

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
Services were offered and accepted by the family and a referral was made. Attempts were made to meet with the family but were unsuccessful. The services case was closed for being unable to locate the family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered and accepted by the family and a referral was made. Attempts were made to meet with the family but were unsuccessful. The services case was closed for being unable to locate the family.

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?	No

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)
04/21/2022	Deceased Child, Female, 8 Years	Mother, Female, 30 Years	Lack of Medical Care	Substantiated	Yes

Report Summary:
The mother was aware the SC had asthma and respiratory issues and the SC required at least one dose of Albuterol and saline solution during the time the SC was away from home. The SC was developmentally disabled and had cerebral atrophy, a g-tube, and scoliosis which made it hard for the SC to cough up phlegm. The mother was advised in March 2022, that the SC needed a refill of both medications and had not responded to any outreach that was made regarding the medications. Therefore, the SC had missed 8 doses of her medication as a result of the mother's inaction.

Report Determination: Indicated **Date of Determination:** 06/10/2022

Basis for Determination:
The SC had a complex list of medical diagnoses and there had been concerns the mother was not giving the SC her medications. The school had made several attempts to reach the mother to help correct the concerns. The school offered to pick up the medication and/or assist the family with any barriers they might have had in getting the medication to the school. The SC missed 8 days of medications. The mother admitted she was not giving the SC her medications as prescribed. The SC was supposed to have a suction machine that was unable to be delivered and the order was cancelled because the mother was unable to be reached.

OCFS Review Results:
MCDHS began their investigation in a timely manner and checked history within the required time frame. The father was interviewed but not face-to-face. The record reflected the mother had taken the SSs to a medical appointment; however, the record did not reflect MCDHS followed up regarding the outcome of the appointment. The record showed that case notes and safety assessments were completed by MCDHS in a timely manner.

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

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

Summary:
The mother had a history of not following through with medical appointments for the children. Although, MCDHS confirmed the mother took the SSs for a well child visit prior to the case closure, the record did not reflect MCDHS followed up regarding the outcome of the visit.

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

Action:
In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. 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)	Allegation Outcome	Compliance Issue(s)
05/21/2021	Deceased Child, Female, 7 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 7 Years	Mother, Female, 29 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 7 Years	Other - unknown, unknown, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 7 Years	Other - unknown, unknown, Male, 30 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The SC had global physical developmental disabilities, intellectual disabilities, was nonverbal, wheelchair bound, and had a feeding tube. The SC received all her basic skills therapy, occupational therapy, speech therapy and the casting for her hand and feet braces at her school program. The mother and parent substitute stopped sending the SC to school for her two in person school days a week. Therefore, the SC had not received any of her therapy sessions since the first week of April 2021. The SS and the father had no role.

Report Determination: Unfounded **Date of Determination:** 08/05/2021

Basis for Determination:
The allegations of IG and LMC were unsubstantiated due to a lack of credible evidence that the SC's medical care was not being adequately addressed. The SM and the BF denied the allegations and stated that they had been providing the services at home and they had been taught how to provide the physical therapy and occupational therapy. The BF denied that the SC was having any issues with her feeding tube and confirmed she was doing well at home with them. The SM worked with the school to have the SC return to remote learning due to health concerns. Services were offered to the family, and they declined.

OCFS Review Results:
The pediatrician had concerns the SC's suction machine and hand splints were not being used. There was no documentation from orthology that the splints were ever picked up. There were also concerns the mother was not following through with medical appointments for the SC. The record did not reflect that MCDHS followed up with the parents regarding these concerns. Despite the parents having a history of lack of follow through with medical appointments for the child, there was no legal consult documented. It was not clearly identified from the case record who the unknown person listed on the SCR report was referring to.

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

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

Summary:
The case was pre-determined to the assessment of the allegations. MCDHS did not attempt to observe the splints for the SC at the mother's home. The SS was not questioned about the allegations. There was no follow up with relevant collateral contacts that could have potentially provided further information.

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:
Assessment as to need for Family Court Action

Summary:

The mother and father had a history of neglecting the medical needs for the SC and the 11-year-old SS. Although the concerns continued in this investigation, there was no legal consult.

Legal Reference:

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

Action:

MCDHS 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/03/2019	Deceased Child, Female, 5 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Female, 5 Years	Mother, Female, 27 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 5 Years	Mother, Female, 27 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Female, 5 Years	Father, Male, 27 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 5 Years	Father, Male, 27 Years	Lack of Medical Care	Substantiated	

Report Summary:

The SC child had medical issues that included cerebellar atrophy, neuroaxonal dystrophy and neuromuscular scoliosis. She was in a wheelchair and had a feeding tube. The mother was not feeding the SC adequately and the SC was underweight as a result. The mother was not following through with the SC's medical appointments and she was missing school where she received her special services. The SC's wrists and muscles were weakening. The mother had not picked up the SC's necessary casts and braces. The MGM's role was unknown.

Report Determination: Indicated | **Date of Determination:** 07/10/2019

Basis for Determination:

The SC had several medical diagnoses, was non-verbal, wheelchair bound and had a feeding tube. The SC had lost a significant amount of weight. The BF and MGM refused to talk with MCDHS about the allegations in the report and it was hard to determine who was feeding the SC while the BM worked full time. The BM took the SC to one appointment at the orthopedist but had missed two others. The BM had not picked up the SC's wrist braces. The BM had not set up an appointment with neurology for the SC as requested by the doctor. The BM did not follow through with services. A legal consult was initiated but no court action was taken.

OCFS Review Results:

MCDHS began the investigation and completed the 7-day safety assessment in a timely manner. The record did not reflect that a notice of existence letter or an indication letter was sent to the MGM, who was listed on the report. MCDHS missed opportunities to speak with collaterals to gather more information regarding the SC and the record does not reflect the MGM was interviewed regarding the report. MCDHS consulted with the legal department and no family court action was taken. MCDHS referred the family to services.

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

Issue:

Failure to provide notice of report

Summary:

MCDHS did not provide notification letters to the required adults in a timely manner.

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.

Issue:

Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:

The MGM was listed on the SCR report with an unknown role. The record did not indicate that MCDHS attempted to locate or interview the MGM or report her in error on the report.

Legal Reference:

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

Action:

A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:

Failure to Provide Notice of Indication

Summary:

The record did not reflect that MCDHS provided an indication letter to the MGM who was an other person named in the report.

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

Action:

MCDHS shall deliver or mail to the subject(s) and other persons named in the indicated report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

[redacted]

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

Between 2014 to 2019, the mother was named as a subject in three CPS investigations with allegations of IG, I/F/C/S, SA, LMC, and M/FTTH. Of those investigations, one was indicated for IG, LMC, and M/FTTH regarding the SC and for IG and LMC regarding the SS.

SCR report dated 2/15/18 to 8/27/2018, with allegations of IG and LMC against the mother regarding the SS, was tracked FAR.

Between 2014 to 2019, the father was named as a subject in three CPS investigations with allegations of IG, SA, LMC, L/B/W, and M/FTTH. Of those investigations, two were indicated for IG, LMC, and M/FTTH regarding the SC and for IG, LBW, and LMC regarding the SS.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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