Child Fatality Report

Report Identification Number: RO-17-035

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

Issue Date: Mar 12, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Office of Children and Family Services

Child Fatality Report

Case Information

Report Type: Child Deceased
Jurisdiction: Monroe
Date of Death: 09/27/2017
Age: 6 month(s)
Gender: Male
Initial Date OCFS Notified: 09/27/2017

Presenting Information

On 9/26/2017, MGM placed SC (6 months old) down for a nap in an adult bed. There was at least one comforter on the bed. Before leaving the home around 12:00 PM, MGM informed SM that SC was on the bed. SM failed to check on SC in a timely manner and he was on the bed unattended for approximately 3 hours. At 2:50 PM, SC was found unresponsive and a comforter was covering his head; his lips and limbs were blue. SC passed away on 9/27/2017 at 8:51 PM. SC had a pre-existing mild cardiac condition and this condition did not contribute to his death. He also had a common cold. The roles of MGM and the 5 SS were unknown.

Executive Summary

On 9/27/2017, Monroe County Department of Human Services (MCDHS) received an SCR report regarding the death of the 6-month-old SC. The fatality investigation was subsequent to an SCR report that was received on 9/26/2017, regarding the incident that led to SC's death, as well as an open FAR case that was received on 7/11/2017 with concerns for SM's drug use and supervision concerns.

On 9/26/2017, around 2:50 PM, SM found the SC unresponsive on his back on an adult bed, with a comforter wrapped around him and covering his head. SM began CPR. The 17 yo SS returned home from school a few minutes later and called 911 at 3:05 PM. SC was transported via ambulance to the hospital, where he remained on life support in critical condition. SC passed away on 9/27/2017 at 8:51 PM, after life support was withdrawn.

The final autopsy report was not available for review at the time of this writing; the cause and manner of death are pending. MCDHS conducted a joint investigation with LE. The LE investigation closed with no criminal charges filed. LE, EMS and hospital staff reported there were no signs of trauma on SC's body. Hospital records showed SC was found in cardiac arrest approximately 3 hours after being placed on an adult bed for a nap. Records stated the cause of the cardiac arrest remained unknown, but was unlikely related to SC's pre-diagnosed heart condition.

MCDHS assessed the safety of the SS within 24 hours and interviewed SM, the 4 oldest SS, MGM, and the BFs of the 17, 6 and 1 yo SS. Although MCDHS engaged and spoke to BF of 1 yo SS, they failed to add him to the case and provide him with a Notice of Existence of the report. Although MCDHS assessed ongoing safety of the SS, they did not complete a 7-day safety assessment. MCDHS contacted multiple collaterals, including LE, EMS, ME, hospital staff, pediatrician, school staff, 17 yo SS's probation officer and several family members. SC was reported to be healthy, except for a minor cold, and developmentally on target. The investigation revealed concerns for SM's untreated MH, marijuana use, supervision concerns, recent altercations with ex-boyfriends, and a lack of follow through with service referrals and SS's medical appointments. On 10/23/2017, MCDHS filed an Article 10 Neglect Petition in Family Court against SM. An OOS and OP were issued.

MCDHS substantiated the allegations of IG and LS against SM regarding all 6 CHN, PD/AM regarding the 17, 11, 9, 6, and 1 yo SS as well as CD/A regarding the 17 yo SS. It was determined MGM placed SC on his stomach on a queen-sized mattress for a nap, with a comforter under him and his head on a pillow. MGM informed SM SC was awake on the bed and then she left the home. SM confirmed she was aware SC was awake on the bed, and she left him in a room on another level of the home without supervision for an extended period. SM had been educated about safe sleep guidelines on multiple occasions and failed to utilize the 2 portable cribs in the home. It was concluded SC was placed at imminent risk of harm due to the unsafe sleep environment and the risk of him rolling off the bed. The allegation of DOA/Fatality was

unsubstantiated against SM regarding SC. The autopsy results remained pending and MCDHS found there was no credible evidence to support that SM inflicted, or allowed to be inflicted a serious physical injury that caused SC's death. The case was opened for ongoing CPS services and a referral was made for preventive daycare and trauma services with Society for the Protection and Care of Children (SPCC).

PIP Requirement

MCDHS will submit a PIP to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) the 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 on-going 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:

Safety was adequately assessed and the case was appropriately indicated.

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:

The case was appropriately indicated and opened for ongoing CPS services.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment

Summary:	MCDHS did not complete a 7-day safety assessment.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	MCDHS will complete 7-day safety assessments within regulatory required timeframes.
Issue:	Failure to provide notice of report
Summary:	MCDHS failed to provide BF of 1 yo SS with a Notice of Existence letter.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/27/2017 **Time of Death:** 08:51 PM

Date of fatal incident, if different than date of death: 09/26/2017
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 03:05 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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
How long before incident was the child last seen by caretaker? 3 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	Male	6 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	71 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	9 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	17 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	11 Year(s)
Other Household 1	Other Adult - BF of 9 yo SS	No Role	Male	49 Year(s)
Other Household 2	Other Adult - BF of 17 yo SS	No Role	Male	46 Year(s)
Other Household 3	Other Adult - BF of 1 yo SS	No Role	Male	46 Year(s)
Other Household 4	Other Adult - BF of 6 yo SS	No Role	Male	31 Year(s)

LDSS Response

MCDHS began their investigation into the incident that lead to SC's death, after receipt of a report on 9/26/2017. Through interviews conducted by MCDHS and LE, it was learned MGM resided in the home with SM and the 6 CHN. SM worked overnight shifts and MGM babysat the CHN. SC was born with a mild cardiac condition that had no affect on his health; he had a common cold.

Regarding the incident on 9/26/2017, it was learned SM came home from work around 7:30 AM after working a double shift. The 4 oldest SS later left for school. At 12:00 PM, MGM laid SC down for a nap in an upstairs bedroom in the home. She placed SC on his stomach with his head on a pillow and comforter under him on a queen-sized mattress. MGM informed SM, who was downstairs with 1 yo SS, that SC was awake on the bed and she then left the home. SM and 1 yo SS fell asleep on the couch downstairs in the home. SM awoke and checked on SC around 2:50 PM. She found him on his back wrapped in the comforter, which was covering his head. SC was not breathing; his limbs and lips were blue and his body was warm. SM brought SC into 17 yo SS's bedroom and began CPR. SM went downstairs a few minutes later, leaving SC upstairs, to open the locked door for 17 yo SS. SM told SS she thought SC was dead and SS called 911. SC was transported to the hospital via ambulance, where he regained a heartbeat and was placed on life support. SC passed away on 9/27/2017 when life support was withdrawn. SM initially stated she was sleeping when MGM left and denied seeing SC since she left for work on 9/25/2017. In later interviews, SM revealed she was awake and went upstairs when MGM left and observed SC awake on his back on top of the comforter.

MCDHS assessed the safety of the 5 SS and interviewed the 4 oldest. It was reported SC always slept on an adult bed or the couch in the home, and usually with SM, MGM or the SS. The home was observed to meet minimal standards and there were 2 portable cribs observed in the home that were not being utilized for the SC or 1 yo SS. SM was interviewed and admitted she had been educated previously about safe sleep practices by MCDHS. SM had a history of regular marijuana use, although denied using while caring for the CHN. There was no information gathered to suggest SM or MGM were under the influence of drugs or alcohol at the time of the incident. MCDHS offered SM MH counseling and substance abuse services, which she declined. SM initially accepted SPCC trauma services, a referral was made, then SM declined the service.

MCDHS spoke to the BFs of the 17, 6 and 1 yo SS. BF of the 11 yo SS was deceased and BF of 9 yo SS was unable to be located. SM alleged two of her ex-boyfriends were BF of the SC; one was ruled out through a paternity test, the second

denied being SC's father and did not complete a paternity test.

MCDHS contacted the necessary collaterals and gathered sufficient documentation to determine the allegations. The final autopsy report was pending further investigation and the manner and cause of death had yet to be determined, although there was no trauma noted on SC's body. There were no criminal charges filed against SM as a result of the LE investigation. Medical, LE and EMS records reviewed confirmed SC was placed on an adult bed for a nap and SM failed to check on him for about 3 hours. SC was in cardiac arrest and unresponsive when EMS arrived and when SC arrived at the hospital.

MCDHS appropriately substantiated the allegation of IG against SM regarding SC. During the investigation, concerns arose that required MCDHS to file an Article 10 Neglect Petition in Family Court against SM. As a result, there was an OOS and OP issued. Allegations were appropriately added to the report to address these concerns and substantiated regarding the SC and SS. The case remained open for ongoing CPS services and a referral was made for SPCC trauma services.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
044172 - Deceased Child, Male, 6 Mons	044173 - Mother, Female, 33 Year(s)	Lack of Supervision	Substantiated
044172 - Deceased Child, Male, 6 Mons	044173 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
044172 - Deceased Child, Male, 6 Mons	044173 - Mother, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
044175 - Sibling, Male, 17 Year(s)	044173 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
044175 - Sibling, Male, 17 Year(s)	044173 - Mother, Female, 33 Year(s)	Childs Drug / Alcohol Use	Substantiated
044175 - Sibling, Male, 17 Year(s)	044173 - Mother, Female, 33 Year(s)	Lack of Supervision	Substantiated
044175 - Sibling, Male, 17 Year(s)	044173 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
044176 - Sibling, Female, 11 Year(s)	044173 - Mother, Female, 33 Year(s)	Lack of Supervision	Substantiated

044176 - Sibling, Female, 11 Year(s)	044173 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
044176 - Sibling, Female, 11 Year(s)	044173 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
044177 - Sibling, Male, 9 Year(s)	044173 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
044177 - Sibling, Male, 9 Year(s)	044173 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
044177 - Sibling, Male, 9 Year(s)	044173 - Mother, Female, 33 Year(s)	Lack of Supervision	Substantiated
044178 - Sibling, Male, 6 Year(s)	044173 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
044178 - Sibling, Male, 6 Year(s)	044173 - Mother, Female, 33 Year(s)	Lack of Supervision	Substantiated
044178 - Sibling, Male, 6 Year(s)	044173 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
044179 - Sibling, Male, 1 Year(s)	044173 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
044179 - Sibling, Male, 1 Year(s)	044173 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
044179 - Sibling, Male, 1 Year(s)	044173 - Mother, Female, 33 Year(s)	Lack of Supervision	Substantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:

BF of 9 yo SS was not interviewed, although attempts were made to locate him. BF of 1 yo was interviewed, although was not added to the case or provided with the required notification.

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:
A 7-day safety assessment was not completed.

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?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
10/23/2017	There was not a fact finding	Order of Supervision
Respondent:	044173 Mother Female 33 Year(s)	
Comments:	MCDHS filed an Article 10 Neglect Petition against SM in Family Court on 10/23/2017. An OOS was granted at the initial court appearance along with an OP. It was ordered SM must comply with preventive daycare, SPCC trauma services, safe sleep for the SS, the SS must be supervised by someone approved by MCDHS and not left alone in the care of the 17 yo SS, the 6 yo SS must have an evaluation and SM must have a MH evaluation.	

Have any Orders of Protection been issued? Yes	
From: 10/23/2017	**To:** Unknown
Explain: An OOS and OP were granted at the initial court appearance for the Article 10 Neglect Petition. It was ordered SM must comply with preventive daycare, SPCC trauma services, safe sleep for the SS, the SS must be supervised by someone approved by MCDHS and not left alone in the care of the 17 yo SS, the 6 yo SS must have an evaluation and SM must have a MH evaluation.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☒	☐	☐	☐	☐	☐	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐

Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☒	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☒	☐	☐	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☒	☐	☐	☐	☐	☐
Child Care	☒	☐	☐	☐	☐	☐	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
MCDHS purchased a bed and linens for SM and assisted SM in obtaining Preventive daycare for 1 yo SS. SM was offered MH and substance abuse services, which she declined. SM initially accepted SPCC trauma services, then declined the service; SM was later court ordered to comply.

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:
MCDHS referred the family to SPCC trauma services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDHS referred the family to SPCC trauma services. MCDHS contacted mobile crisis for a MH consultation for SM.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
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 fetal alcohol effects or syndrome
☐ With neither of the issues listed noted in case record

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)
09/26/2017	Sibling, Male, 17 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	No
	Sibling, Female, 11 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 11 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated	
	Sibling, Male, 6 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 1 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated	
	Deceased Child, Male, 6 Months	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 17 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 9 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 1 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 17 Years	Mother, Female, 33 Years	Childs Drug / Alcohol Use	Indicated	
	Deceased Child, Male, 6 Months	Grandparent, Female, 71 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 6 Months	Grandparent, Female, 71 Years	Lack of Supervision	Indicated	
	Sibling, Male, 9 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 6 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated	
	Sibling, Male, 6 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated	
	Deceased Child, Male, 6 Months	Mother, Female, 33 Years	Lack of Supervision	Indicated	
	Sibling, Male, 17 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated	
	Sibling, Male, 9 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated	

	Sibling, Male, 1 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
	Sibling, Female, 11 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated

Report Summary:
An SCR report alleged on 9/26/17, MGM put SC down for a nap on the bed with a comforter. MGM then left the residence and notified SM that SC was napping. SM failed to check on SC until about 2:50 PM when she found him unresponsive with the comforter over his face. SC was taken to the hospital where he was revived around 3:50 PM. The SS had an unknown role.

Determination: Indicated | **Date of Determination:** 12/01/2018

Basis for Determination:
MCDHS appropriately added the allegations of the initial FAR case to this investigation and substantiated all allegations against SM regarding the SC and SS. Due to concerns regarding improper supervision, drug use, domestic violence and for SM's untreated MH, an Article 10 Neglect Petition was filed in Family Court. An Order of Supervision and order of protection were issued and the case was opened for ongoing CPS services. Allegations against MGM were unsubstantiated as she informed SM that she was leaving and that SC was on the bed, and she was not home at the time SC was found unresponsive.

OCFS Review Results:
MCDHS conducted a joint investigation with LE into the incident and the SC's subsequent death. The subjects and family members were interviewed, appropriate collateral contacts were made and necessary documentation was gathered and reviewed. The SS's safety was assessed and a Neglect Petition was appropriately filed to obtain court ordered services due to SM's lack of follow though with prior referrals for services.

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)
07/11/2017	Sibling, Male, 1 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Male, 6 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 3 Months	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 9 Years	Mother, Female, 33 Years	Lack of Supervision	Far-Closed	
	Sibling, Male, 17 Years	Mother, Female, 33 Years	Childs Drug / Alcohol Use	Far-Closed	
	Sibling, Female, 11 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 6 Years	Mother, Female, 33 Years	Lack of Supervision	Far-Closed	
	Deceased Child, Male, 3 Months	Mother, Female, 33 Years	Lack of Supervision	Far-Closed	
	Sibling, Male, 9 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report alleged SM smoked marijuana with 17 yo SS. Knowing that 17 yo SS smoked marijuana, she continued

to leave the SS in his care every night, overnight, while she worked. It also alleged none of the SS woke in the middle of the night to feed SC and that SM left SC in the care of the 6 and 9 yo SS, who due to their ages, and the fact that the 6 yo had a history of starting fires, should not be left unsupervised or caring for an infant.

OCFS Review Results:
MCDHS appropriately tracked the case FAR within the required timeframe. They added the BFs to the case and provided Notice of Existence and Notice of Closure letters to SM and the BFs. The first alleged BF of SC was spoken to and his home was assessed to be safe, although a paternity test later established he was not the BF of the SC. MCDHS engaged the family and contacted necessary collaterals. The case was appropriately closed on 10/2/2017, after a subsequent SCR report was received on 9/26/2017, regarding the incident that resulted in SC's death. The allegations of the FAR case were correctly added to the subsequent investigation.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
MCDHS entered multiple progress notes non-contemporaneously, up to 2 months after the event date.
Legal Reference:
18 NYCRR 428.5
Action:
MCDHS will enter all progress notes contemporaneously.

Issue:
Failure to provide safe sleep education/information
Summary:
MCDHS did not assess the sleeping arrangements for the CHN or assess for a safe sleep environment for the SC during the initial or ongoing assessments of the home.
Legal Reference:
13-OCFS-ADM-02
Action:
For FAR cases, the initial safety assessment and any periodic assessments of risk must include an assessment of the sleeping arrangements for the children in the home. If the parent or caregiver of an infant does not have a crib, cradle, bassinet, bedside co-sleeper, or play yard and does not have the financial means to obtain one, MCDHS must assist the parent or caregiver.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/27/2017	Deceased Child, Male, 1 Days	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Far-Closed	Yes

Report Summary:
An SCR report alleged SM gave birth to SC on 3/26/2017, and he tested positive for marijuana at the time of the delivery. The 5 SS had unknown roles.

OCFS Review Results:
MCDHS appropriately tracked the case FAR within the required timeframe. They added the BFs to the case and provided Notice of Existence and Notice of Closure letters to SM and the BFs. MCDHS engaged the family and contacted necessary collaterals. MCDHS provided SM with food vouchers and safe sleep education. MCDHS offered SM Preventive Services and she declined. The case closed on 7/10/2017, when a referral was made for SM to engage in MH treatment.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
MCDHS entered multiple progress notes non-contemporaneously, up to 3 months after the event date.
Legal Reference:
18 NYCRR 428.5
Action:
MCDHS will enter all progress notes contemporaneously.

Issue:
FAR-Failure to Offer and/or Provide Needed Services
Summary:
MCDHS identified SM's drug use as a risk factor for the CHN and failed to refer SM for substance abuse treatment.
Legal Reference:
18 NYCRR 432.13 (e)(2) (vi) & (vii)
Action:
FAR workers must offer assistance to the family in implementing solutions to their identified needs that will be supportive of family functioning, meet the CHN's needs and reduce risk to CHN in the family.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/22/2016	Sibling, Female, 10 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Far-Closed	No
	Sibling, Female, 10 Years	Mother, Female, 32 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 16 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 16 Years	Mother, Female, 32 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 5 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 5 Years	Mother, Female, 32 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 9 Months	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 9 Months	Mother, Female, 32 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report alleged there was not enough food in the home and the SS missed meals and were hungry. The home was unsanitary and hazardous to the SS. Subsequent SCR report received 11/2/2016 with similar concerns and was merged.

OCFS Review Results:
MCDHS appropriately tracked the case FAR within the required timeframe and merged the subsequent report into the open FAR case. They added the BFs to the case and provided Notice of Existence and Notice of Closure letters to SM and the BFs. MCDHS engaged the family and contacted necessary collaterals. MCDHS assisted SM in obtaining a refrigerator, stove, beds, and linens. The case closed on 3/16/2017, when all service needs were identified and addressed.

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)
03/15/2016	Sibling, Male, 15 Years	Mother, Female, 32 Years	Lacerations / Bruises / Welts	Far-Closed	No
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Lacerations / Bruises / Welts	Far-Closed	
	Sibling, Male, 15 Years	Mother, Female, 32 Years	Lack of Medical Care	Far-Closed	
	Sibling, Male, 15 Years	Mother, Female, 32 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 15 Years	Mother's Partner, Male, 44 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report alleged on 3/14/2016, SM was angry and out of control because 9 yo SS misbehaved. SM punched SS in the stomach so hard that SS vomited and was experiencing tenderness in his stomach. On 3/15/2016, SM was angry with SS again and beat him with a belt and punched SS in the forehead, causing a bruise on his forehead. SM was also failing to seek medical treatment for SS, as he was often out of his medication, and engaged in physical altercations with 17 yo SS. A subsequent report was received and merged, with allegations SM and PS engaged in an argument with 17 yo SS that resulted in PS pulling out a pipe and degrading SS. SS pulled out a knife to defend himself.

OCFS Review Results:
MCDHS appropriately tracked the case FAR within the required timeframe and merged the subsequent report into the open FAR case. They added the BFs to the case and provided Notice of Existence and Notice of Closure letters to SM and the BFs. MCDHS engaged the family and contacted necessary collaterals. MCDHS assisted SM in obtaining furniture and a refrigerator. They coordinated with service providers for 17 yo SS to complete a substance abuse evaluation. The case closed on 5/16/2016, when all service needs were identified and being addressed by service providers.

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)
08/19/2015	Sibling, Male, 7 Years	Mother, Female, 31 Years	Inadequate Guardianship	Far-Closed	No
	Sibling, Male, 7 Years	Mother, Female, 31 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 9 Years	Mother, Female, 31 Years	Lack of Supervision	Far-Closed	

Sibling, Male, 4 Years	Mother, Female, 31 Years	Inadequate Guardianship	Far-Closed
Sibling, Male, 4 Years	Mother, Female, 31 Years	Lacerations / Bruises / Welts	Far-Closed
Sibling, Male, 4 Years	Mother, Female, 31 Years	Swelling / Dislocations / Sprains	Far-Closed
Sibling, Female, 9 Years	Mother, Female, 31 Years	Inadequate Guardianship	Far-Closed
Sibling, Female, 9 Years	Mother, Female, 31 Years	Lacerations / Bruises / Welts	Far-Closed
Sibling, Male, 4 Years	Mother, Female, 31 Years	Lack of Supervision	Far-Closed
Sibling, Male, 7 Years	Mother, Female, 31 Years	Lacerations / Bruises / Welts	Far-Closed

Report Summary:
An SCR report alleged SM was not providing adequate supervision for the SS. The SM left the SS unattended, and as a result, the SS hit and scratched each other causing injuries. A television fell on 6 yo SS's face causing a black eye and swelling to his cheeks.

OCFS Review Results:
MCDHS appropriately tracked the case FAR within the required timeframe. They added the BFs to the case and provided Notice of Existence and Notice of Closure letters to SM and the BFs. MCDHS engaged the family and contacted necessary collaterals. MCDHS provided SM with information on MH counseling resources for her and 17 yo SS and assisted SM in obtaining Temporary Assistance. The case closed on 9/24/2015, when SM had gained support from relatives to assist with daycare and there were no additional service needs identified by the family.

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)
07/15/2014	Sibling, Male, 3 Years	Other Adult - BF of 6 yo SS, Male, 28 Years	Inadequate Guardianship	Far-Closed	No

Report Summary:
An SCR report alleged on 7/15/2014, BF of 6 yo SS brought 6 yo SS to a drug house to buy drugs. While there, the home got raided by the SWAT team, placing SS at risk of harm.

OCFS Review Results:
MCDHS appropriately tracked the case FAR within the required timeframe and provided Notice of Existence and Notice of Closure letters to SM and the BF. MCDHS engaged the family, contacted necessary collaterals and assisted the BF in engaging in substance abuse treatment. The case closed on 9/17/2014, when there were no additional service needs identified by the family.

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

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

12/15/2001 Sub for IG and LS against SM regarding 17 yo SS and another child. SM left the CHN unsupervised for a period of time in a locked car at the airport.

3/13/2008 Unsub for IG against SM regarding 17 yo SS. SS was unable to open his bedroom door for a period of time. SM

denied that she locked SS in his room.

5/31/2009 Sub for IG against SM regarding 17 yo SS, Unsub for LS, PD/AM and XCP against SM regarding 17 yo SS, Unsub for IG, LS and PD/AM against SM regarding 11 and 9 yo SS and Unsub for PD/AM against MGM regarding all 3 SS. An altercation took place where 17 yo SS was choked by another adult and spanked with a belt by SM, although there were no marks. The CHN denied being left without supervision or that SM smoked marijuana in their presence. SS denied MGM was intoxicated while watching them. Case closed- referred to community based services and a Preventive Services case was opened.

1/27/2010 Unsub for Other against SM and 17 yo SS's BF regarding 17 yo SS. Court ordered investigation due to custody proceedings between SM and BF who resided in North Carolina. SM denied physically and sexually abusing 17 yo SS and BF denied incidents of DV. The SS remained in North Carolina with BF and Preventive Services continued with SM and SS.

8/25/2012 report with allegations of IG and IF/C/S against SM regarding 11, 9 and 6 yo SS tracked FAR. The home was safe and met minimal degree, MCDHS assisted SM in obtaining food stamps and the FAR case closed 9/21/2012.

Known CPS History Outside of NYS

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

Preventive Services History

On 9/15/2009, MCDHS opened a Preventive Services case to assist SM with substance abuse, anger management, MH and parenting concerns. SM did not meet with service providers or make progress on her service plan goals, so the Preventive Services case closed on 7/2/2010.

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?	☐	☐	☒	☐

Legal History Within Three Years Prior to the Fatality

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

Additional Local District Comments

"This draft report is factually correct. Note in CONNECTIONS after you have completed your 24 hour fatality report, the OCI doesn't show that you have a 7 day SA due. This accounts for some of the 7 day's going overdue on fatalities."

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