Child Fatality Report

Report Identification Number: RO-17-049

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

Issue Date: May 29, 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		

Case Information

Report Type: Child Deceased
Age: 25 day(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 12/19/2017
Initial Date OCFS Notified: 12/19/2017

Presenting Information

An SCR report was received on 12/19/17, and alleged at approximately 11:20AM, the SM fell asleep with the 25- day-old SC next to her in the bed. The SM awoke at approximately 11:50AM and found the SC unresponsive. The SM called 911 and the SC was taken to the hospital for medical attention. The SC was intubated and transferred to another hospital at approximately 4:45PM. It is unknown if the SC ever regained consciousness. The SC was pronounced dead on 12/19/17 at 8:40PM. At the time of the SC's birth, she had a positive toxicology for cocaine. The SC had no preexisting medical conditions that contributed to her death and she was an otherwise healthy child. Therefore her death is considered suspicious.

There was an open CPS investigation at the time of the fatality. The open report alleged concerns regarding the SC and SM's positive toxicology at the time the SC was born.

Executive Summary

This report concerns the death of a 3-week-old female that occurred on 12/19/17. An SCR report was received by Monroe County Department of Human Services (MCDHS) concerning the fatality on 12/19/17, subsequent to an open CPS investigation. The subsequent report alleged the SM fell asleep with the SC in the bed with her, and awoke to find the SC unresponsive. The SC had no known medical conditions, despite being born premature with a positive toxicology. The SM had a documented history of co-sleeping with the SC, despite safe sleep education from MCDHS and medical providers.

The ME performed an autopsy and the cause and manner of death were pending at the time of this writing. LE investigated the fatality, but the case record does not indicate whether or not criminal charges were pursued as a result of the SC's death.

MCDHS responded to the fatality report immediately by joining LE at the home of the SC, where the SM was interviewed. The SM and SF were both in the bed with the SC when she was found unresponsive. The SM reported that she had fed the SC in the bed and unintentionally fell asleep. When the SM awoke a short time later, the SC was pale and unresponsive. The SM noted she found herself in a different position when she woke, in comparison to when she had fallen asleep. EMS was called and responded. The SC was taken to the ER and resuscitation efforts were unsuccessful.

At the time of the fatality the SC resided in the home with the SM, MGM, BF and her 12yo SS. In addition, the SM was caring for 4 other children (15yo OC, 13yo OC, 9yo OC and 2yo OC). The OC were in the care of the SM as arranged by their BM due to her incarceration.

MCDHS found drug paraphernalia in the SM and BF's bedroom, where the SC slept. MCDHS deemed the conditions in the home to be a hazard to the safety of the children residing in the home. MCDHS spoke with the BM of the OC and she consented to a removal. The four OC were placed into foster care on 12/19/17. The SM and BF refused to consent to the removal of the SS. The BF offered the PGM as a resource and gave MCDHS her address. On 12/19/17, MCDHS documented a conversation with the SM and BF where MCDHS notified the parents that the SS was being removed from their care and custody without their consent. During the same conversation, the SM and BF would not provide the whereabouts of the SS. MCDHS documented no efforts to try to locate the SS, until 12/20/17. On that day the SM called MCDHS and advised them she had located the SS and told them to meet her at the PGM's home. MCDHS did not make

adequate efforts to locate and assess the safety of the SS on 12/19/17.

There is no documentation in the case record that MCDHS spoke with the MGM regarding the events leading up to the fatality. MCDHS had not added allegations against the BF regarding his drug use in the home or death of the SC at the time of this writing, although it would have been appropriate to do so. MCDHS had not made a determination in the investigation at the time this report was written.

MCDHS offered drug evaluation and treatment services to both the SM and BF. The SS and four OC were provided foster care services and visitation.

At the time of this writing the CPS investigation remained open and no determination had been made.

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?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Explain:
The SS whereabouts were not known for a period of about 8 hours and MCDHS failed to make appropriate arrangements to assess her safety.

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The CPS investigation remained open at the time of this writing.

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 CPS investigation remained open at the time of this writing and a Foster Care case was opened in response to the fatality.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	On 12/19/2017 MCDHS documented the SS was at imminent risk of harm and a removal from the care of her parents was warranted, and failed to take appropriate action to protect the SS. No efforts to locate the SS were made until the following day.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	MCDHS will take immediate action to locate and protect children that are deemed to be in imminent risk of harm. MCDHS will exhaust all options to locate a child when a removal is neccessary and document their efforts in the case record. MCDHS will make adequate safety plans.
Issue:	Adequacy of Progress Notes
Summary:	MCDHS entered several notes into the CPS case open at the time of the fatality regarding events that occurred as the result of the fatality. These notes were not in the fatality investigation, although they were pertinent.
Legal Reference:	18 NYCRR 428.5
Action:	MCDHS will document all case activity that occurs during the course of a fatality investigation, within the fatality investigation, regardless of concurrent investigations.
Issue:	Review of CPS History
Summary:	MCDHS did not document a review of the CPS history in the time frame prescribed.
Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	Within 1 business day of a report, MCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child's sibling, and, for indicated reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	Allegations were not added to the investigation regarding the BF of the SC. The investigation revealed the BF was also in the bed at the time of the fatal incident and had been using drugs the evening prior to the fatality.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:	MCDHS will conduct thorough investigations and consider all evidence gathered to determine allegations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/19/2017 **Time of Death:** 08:40 PM

Time of fatal incident, if different than time of death: 11:20 AM

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 11:55 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	25 Day(s)
Deceased Child's Household	Father	No Role	Male	42 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	61 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Other Child - Child the SM was caring for	No Role	Female	2 Year(s)
Deceased Child's Household	Other Child - Child the SM was caring for	No Role	Female	15 Year(s)
Deceased Child's Household	Other Child - Child the SM was caring for	No Role	Female	13 Year(s)
Deceased Child's Household	Other Child - Child the SM was caring for	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Other Household 1	Other Adult - BM to OC	No Role	Female	30 Year(s)
Other Household 2	Other Adult - BF to youngest two OC	No Role	Male	27 Year(s)

Other Household 3	Other Adult - BF to Eldest two OC	No Role	Male	34 Year(s)

LDSS Response

On 12/19/2017, MCDHS received a report regarding the death of the SC. MCDHS initiated their investigation within 24 hours, and coordinated their efforts with LE. MCDHS completed a home visit immediately after receiving notification of the SC's death. LE was already present at the home, in addition to the SM, BF, MGM and the 15yo and 2yo OC.

MCDHS observed LE's interview of the SM. On the morning of 12/19/17, the SM was sleeping in her full-size bed with the BF and SC. The SM stated the SC normally slept in a bassinet in the bedroom and denied that she regularly slept in the bed. The SM awoke between 8:30-9:00AM. At 10:00AM, the SM fed the SC while they were both lying down in the bed, and the SM fell asleep. The SM woke up and saw the SC lying to her side unresponsive. The SM's arm was underneath the SC when they fell asleep. When the SM woke her arm was not under the SC and the SM had turned in her sleep and her back was facing the SC. The SC was positioned on her back, on top of a pillow on the bed. The BF slept on the other side of the bed and was not near the SC. The SM called 911 after discovering the SC pale and not breathing. It is unclear how the BF reacted when the SC was found unresponsive. The SM also reported the SC had blood coming from her nose and her forehead appeared bruised. The SM performed CPR as instructed by 911, until LE arrived and took over resuscitation efforts. The SC was taken by ambulance to the ER. The SM and BF drove in a car to the ER, while leaving the OC home with the MGM that also resided in the home.

The SM admitted to cocaine use, but stated she had not used since her pregnancy. The SM and BF reported the BF was an active heroin user. The SM denied that the BF or herself had used drugs the day of the fatality. The BF told LE he had used heroin the night before the SC's death. MCDHS found drug paraphernalia in the SM's bedroom and all were accessible to the CHN in the home. The SM attended a substance abuse evaluation and was recommended for inpatient treatment. The BF was recommended for a substance abuse evaluation but it is unclear if he followed through with the recommendation.

There was a bassinet and crib for the SC in the SM's bedroom, but both were filled with items and did not appear to be in use. The SM had been educated in the hospital multiple times about the dangers of co-sleeping with the SC. Hospital personnel reported the SM had to be repeatedly told not to have the SC in the bed with her while they were in the maternity unit.

The 15yo OC reported the SM awoke her at 12:00PM the day of the fatal incident. The 15yo had no knowledge of what had occurred and EMS had already left the home to transport the SC to the ER. The 15yo reported she believed the SC slept in a bassinet in the SM's room, but the 15yo had never been in the SM's bedroom. The 2yo OC was observed running around the home. It was not clear where the 2yo was at the time of the fatal incident. The 9yo OC arrived home from school and was interviewed. The 9yo had no knowledge of the incident. The 9yo reported that in the past he had seen the SM sleeping on the couch with the SC, as well as the SC sleeping in a "Rock N Play." The 9yo explained the SC would be positioned on her back on the couch between the SM's back and the back of the couch. The 13yo OC and 12yo SS were interviewed at school, and neither had information about the death of the SC.

The first LE to respond reported the SM was sitting in a chair with the SC and there was no CPR in progress when he arrived. MCDHS reviewed hospital records for the SC. The SC was resuscitated and intubated at the ER. The SC then went into cardiac arrest and further CPR efforts were futile.

MCDHS deemed the conditions of the SM's home unsafe for all the CHN due to drug use. The four OC were removed with the consent of the BM, and placed in FC on 12/19/17. The 12yo SS was placed into FC on 12/20/17, because MCDHS did not locate the SS on 12/19/17.

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
043481 - Deceased Child, Female, 25 Days	044162 - Mother, Female, 36 Year(s)	DOA / Fatality	Pending
043481 - Deceased Child, Female, 25 Days	044162 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Pending
043481 - Deceased Child, Female, 25 Days	044162 - Mother, Female, 36 Year(s)	Parents Drug / Alcohol Misuse	Pending

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:
EMS and the MGM of the SC was not interviewed regarding the fatality.

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?	☒	☐	☐	☐
Explain: The OC were removed on 12/19/17 and the SS was not removed until 12/20/17. The BF stated the SS could go to her PGM's home. Although the PGM's address was known, MCDHS made no effort to take the SS into physical custody until the following day, and no appropriate safety plan was made.				
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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The SS and 4 OC were removed after the discovery of illicit drugs and drug paraphernalia accessible to the children within the SC's home.

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:**
	There was not a fact finding	There was not a disposition
Respondent:	044162 Mother Female 36 Year(s)	
Comments:		

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: There was an OP put in place against the SM and BF in regard to the SS	

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 removed the SS and opened a case with the SM and BF regarding the SS. At the time of this writing the SM and BF were not cooperative with MCDHS and linking to needed services.

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? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)

11/02/2017	Deceased Child, Female, 2 Days	Father, Male, 42 Years	Inadequate Guardianship	Indicated	Yes
	Other Child - Child the SM was caring for, Male, 9 Years	Mother, Female, 36 Years	Inadequate Guardianship	Indicated	
	Other Child - Child the SM was caring for, Female, 13 Years	Mother, Female, 36 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 12 Years	Mother, Female, 36 Years	Inadequate Guardianship	Indicated	
	Other Child - Child the SM was caring for, Female, 13 Years	Father, Male, 42 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 12 Years	Father, Male, 42 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Female, 2 Days	Grandparent, Female, 61 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 12 Years	Grandparent, Female, 61 Years	Inadequate Guardianship	Indicated	
	Other Child - Child the SM was caring for, Female, 15 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Indicated	
	Other Child - Child the SM was caring for, Male, 9 Years	Father, Male, 42 Years	Parents Drug / Alcohol Misuse	Indicated	
	Other Child - Child the SM was caring for, Female, 2 Years	Father, Male, 42 Years	Parents Drug / Alcohol Misuse	Indicated	
	Other Child - Child the SM was caring for, Female, 2 Years	Grandparent, Female, 61 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Female, 2 Days	Father, Male, 42 Years	Parents Drug / Alcohol Misuse	Indicated	
	Deceased Child, Female, 2 Days	Mother, Female, 36 Years	Inadequate Guardianship	Indicated	
	Other Child - Child the SM was caring for, Female, 15 Years	Mother, Female, 36 Years	Inadequate Guardianship	Indicated	
	Other Child - Child the SM was caring for, Male, 9 Years	Father, Male, 42 Years	Inadequate Guardianship	Indicated	
	Other Child - Child the SM was caring for, Female, 13 Years	Grandparent, Female, 61 Years	Inadequate Guardianship	Indicated	
	Other Child - Child the SM was caring for, Male, 9 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Indicated	
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	Sibling, Female, 12 Years	Father, Male, 42 Years	Parents Drug / Alcohol Misuse	Indicated	
	Other Child - Child the SM was caring for, Male, 9 Years	Grandparent, Female, 61 Years	Inadequate Guardianship	Indicated	

Other Child - Child the SM was caring for, Female, 2 Years	Mother, Female, 36 Years	Inadequate Guardianship	Indicated
Other Child - Child the SM was caring for, Female, 15 Years	Father, Male, 42 Years	Inadequate Guardianship	Indicated
Other Child - Child the SM was caring for, Female, 2 Years	Father, Male, 42 Years	Inadequate Guardianship	Indicated
Other Child - Child the SM was caring for, Female, 15 Years	Grandparent, Female, 61 Years	Inadequate Guardianship	Indicated
Other Child - Child the SM was caring for, Female, 13 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Indicated
Other Child - Child the SM was caring for, Female, 2 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 12 Years	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Indicated

Report Summary:
An SCR report was received and alleged that the SM was forcefully punching the 9yo and hitting him with a belt for unknown reasons. It was occurring regularly and the OC was hit multiple times during the occurrences. It was unknown if the OC sustained injuries as a result.

A subsequent SCR report was received regarding the SM and SC having a positive toxicology for cocaine at the time of the SC's birth.

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

Basis for Determination:
MCDHS indicated the investigation based on the evidence they gathered, which showed there was regular drug use occurring in the home and around the CHN. The SM tested positive throughout the investigation and the SF admitted to drug use. There were drugs and drug paraphernalia found in the home. The CHN all denied any physical discipline. MCDHS added allegations against the MGM, because she resided in the home and was also responsible for the maltreatment of the CHN.

OCFS Review Results:
The SM denied using physical discipline on any of the CHN. The OC had explanations for marks that were seen on his body and denied he had experienced any physical discipline. When the SC was born, MCDHS was advised the SM repeatedly put the child in the bed with her at the hospital, despite numerous warnings not to do so by hospital staff, in addition to conversations about safe sleep. MCDHS addressed all concerns in the investigation as they arose.

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

Issue:
Review of CPS History

Summary:
The SCR report was received on 11/2/17 and a history review was documented on 12/1/17. The review of history was not completed in the required timeframe.

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/01/2017	Other Child - Child SM is caring for, Female, 14 Years	Mother, Female, 35 Years	Burns / Scalding	Unfounded	Yes
	Other Child - Child SM is caring for, Female, 14 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	Other Child - Child SM is caring for, Female, 14 Years	Mother, Female, 35 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 11 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	

Report Summary:
An SCR report was received regarding a 14yo OC the SM was caring for with allegations the SM was leaving the OC unsupervised for long periods of time, despite the OC's developmental delays. The report stated in the time the OC was left unsupervised, she heated up a knife on the stove and applied it to her arm repeatedly, resulting in 3rd degree burns. There were also allegations the OC was being sexually abused by a 9yo SS in the home and it was unknown where knowledge of these behaviors came from.

Determination: Unfounded **Date of Determination:** 08/09/2017

Basis for Determination:
MCDHS found through interviews with the OC in the home that the event where the 14yo OC burned herself took place in the evening when everyone was at home and asleep. The OC also stated that the SM never left them home alone. The 9yo SS adamantly denied the allegations that she inappropriately touched the OC in any manner. The OC suffered from significant MH issues and developmental delays and had fabricated allegations against other CHN in the past. The OC was hospitalized as a result of her behaviors and the SM could no longer care for her due to her behaviors. The BM voluntarily agreed that the OC could be placed in FC in order to get appropriate treatment.

OCFS Review Results:
MCDHS interviewed all the CHN in the home regarding the allegations. MCDHS also notified and interviewed the BM and BF of the OC regarding the CPS report and the allegations.

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

Issue:
Failure to provide notice of report

Summary:
A notice of existence was not given to a BF and another adult listed on the report. Additionally, the BF of several of the CHN in the home was not notified of the existence of the report.

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

Action:
MCDHS will provide a notice of existence to all adult named on a report. Additionally MCDHS will identify all non-subject (absent) parents and add them to the report for purposes of notification.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/19/2017	Sibling, Female, 11 Years	Mother, Female, 35 Years	Inadequate Guardianship	Far-Closed	Yes

Other Child - Child the SM is caring for, Female, 14 Years	Mother, Female, 35 Years	Burns / Scalding	Far-Closed
Other Child - Child the SM is caring for, Female, 14 Years	Mother, Female, 35 Years	Inadequate Guardianship	Far-Closed
Other Child - Child the SM is caring for, Female, 14 Years	Mother, Female, 35 Years	Lack of Medical Care	Far-Closed

Report Summary:
An SCR report was received stating that the SM was not providing the 13yo OC with her prescribed medication for over 1 month. As a result, the OC was acting out and had a burn on her arm. The SM reported the burn was present when the OC came into her care, but the explanation was suspicious.

OCFS Review Results:
The case was eligible for FAR and the FLAG was completed after multiple home visits and discussions with the family. The children were seen, and when appropriate, interviewed. No concerns in the home and care of the children were found. An alternative living situation was arranged for the 13yo OC before the conclusion on the case.

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

Issue:
FAR-Failure to Provide Notice of Report

Summary:
Notice of report was not given to every adult listed on the report and a BF was not added and notified of the report.

Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:
MCDHS will notify all adults listed of the report as prescribed by law.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/27/2017	Other Child - OC, Female, 13 Years	Other Adult - BM to OC, Female, 29 Years	Inadequate Guardianship	Far-Closed	Yes
	Other Child - OC, Female, 13 Years	Other Adult - BM to OC, Female, 29 Years	Lack of Medical Care	Far-Closed	

Report Summary:
An SCR report was received alleging the BM failed to follow through with scheduling a necessary medical procedure for the OC. The OC required surgery for a shunt in her head and the BM did not make the necessary appointments for the surgery.

OCFS Review Results:
MCDHS had contact with the SM who had assumed informal guardianship of the children during the open case. MCDHS also had contact with the children. Collateral contacts were also made with the school. At the time of the FAR closing, the issue regarding the SC's need for medical treatment had not been addressed.

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

Issue:
FAR-Failure to Provide Notice of Report

Summary:
There was no Notice of Existence of a FAR sent to the BF of the OC, BF of the 2 youngest OC and the SM.

Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:
MCDHS will provide written notification to every parent, guardian or person legally responsible for the care of the children named in the report no later than 7-days after receiving a report that has been assigned to the FAR track.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/09/2016	Other Child - OC, Female, 13 Years	Other Adult - BM to OC, Female, 28 Years	Inadequate Food / Clothing / Shelter	Far-Closed	Yes
	Other Child - OC, Female, 13 Years	Other Adult - BM to OC, Female, 28 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report was received alleging the BM was not properly caring for the OC's hygiene. The report alleged the BM was refusing to purchase necessary female personal hygiene products for the OC and the OC was dirty and disheveled. The OC was supposed to be wearing a helmet due to a medical issue, but the BM was not providing a helmet.

OCFS Review Results:
There were no notes in the case for a period of 3 months. There does not appear to have been contact with the family during this time period, despite having two open FAR cases. In this time period the OC (FAR recipient) was placed in residential care and no longer living in the home. There were ongoing issues that were not addressed because MCDHS had no contact with the family. The case note documentation and activities are inadequate.

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

Issue:
FAR-Failure to Provide Notice of Report
Summary:
There was no Notice of Existence of a FAR sent to the BF of the OC, BF of the 2 youngest OC and the SM.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
MCDHS will provide written notification to every parent, guardian or person legally responsible for the care of the children named in the report no later than 7-days after receiving a report that has been assigned to the FAR track.

Issue:
FAR-Timely/Adequate Documentation
Summary:
There were several cases notes entered 9 months after the event date.
Legal Reference:
18 NYCRR 432.13 (e)(5)
Action:
MCDHS will document case notes contemporaneously in FAR cases.

Issue:
FAR-Overall Completeness/Adequacy of Family Assessment Response
Summary:
There was no documented contact with the family for a period of 3 months. In that time the OC was placed in residential care and MCDHS appeared to have no knowledge of the change in household composition. The required contacts were not made with the family. There were several issues not fully explored and resolved with the family as a result of the lack of casework contact and activities.
Legal Reference:

18 NYCRR 432.13 (a)(1-4)

Action:

MCDHS will have the required contact with families during an open FAR case, and document these contacts. MCDHS will address and document all issues that arise during an open case. When a FAR case is kept open in excess of 90-days, MCDHS will document the reason and document clear steps in which they are working with the family to reach their goals.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/18/2016	Other Child - OC, Female, 13 Years	Other Adult - BF to OC, Male, 26 Years	Inadequate Guardianship	Far-Closed	Yes
	Other Child - OC, Female, 13 Years	Other Adult - BF to OC, Male, 26 Years	Lacerations / Bruises / Welts	Far-Closed	
	Other Child - OC, Female, 13 Years	Other Adult - BM to OC, Female, 28 Years	Inadequate Guardianship	Far-Closed	
	Other Child - OC, Female, 13 Years	Other Adult - BM to OC, Female, 28 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Other Child - OC, Female, 13 Years	Other Adult - BM to OC, Female, 28 Years	Lacerations / Bruises / Welts	Far-Closed	

Report Summary:

An SCR report was received and alleged the BF and BM of the OC had pushed her to the floor and hit her with a belt. The report also alleged the BM allowed another OC to bite the alleged maltreated OC. The OC had bruising to her body and bite marks on her back.

OCFS Review Results:

This was the first of 3 FAR cases opened with the family from 7/18/2016-6/13/2017. MCDHS did not consolidate the cases and kept them all open concurrently. In this case there is no documented contact with the family from 9/13/16-1/14/16, yet the case remained open. Notices of Existence of a FAR were not sent to anyone and the FLAG was not appropriately completed. Many questions were answered inaccurately based on the facts gathered during the contacts with the family and collaterals.

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

Issue:

FAR-Failure to Provide Notice of Report

Summary:

There was no Notice of Existence of a FAR sent to the BF of the OC, BF of the 2 youngest OC and the BM.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:

MCDHS will provide written notification to every parent, guardian or person legally responsible for the care of the children named in the report no later than 7-days after receiving a report that has been assigned to the FAR track.

Issue:

FAR-Timely/Adequate Family-Led Assessment Guide

Summary:

The FAR FLAG was completed on 6/10/17, while the FAR was opened on 7/18/16. Also, many of the questions in the FLAG were not selected appropriately to reflect the current functioning of the family. The intended purpose of the FLAG

is to help plan with the family any services or assistance that may be helpful in reducing risk and increasing protective factors.

Legal Reference:

18 NYCRR 432.13 (e)(2)(iii)-(v)

Action:

MCDHS will accurately answer FLAG questions to reflect the information gathered from assessment of the family at family meetings. MCDHS will complete multiple FLAGS as necessary to accurately reflect the current situation and composition of the family.

Issue:

FAR-Insufficient Number of Casework Contacts

Summary:

There are no documented casework contacts from 9/13/16-1/4/17. When a FAR case is kept open in excess of 90 days, casework contacts must be made once every 2 weeks and documented.

Legal Reference:

18 NYCRR 432.13 (e)(4); 18 NYCRR 432.13 (e)(3)(v)(d)(2)

Action:

MCDHS will comply with the regulation to see families at least once every 2 weeks on FAR cases that have been open more than 90 days.

Issue:

FAR-Failure to Offer and/or Provide Needed Services

Summary:

During the open FAR report there were outside services in place, but the family appeared to struggle with scheduling, keeping appointments, and following through on recommendations. A discussion should have been had about Preventive Services to assist the family. When a FAR case is open more than 90 days there should be documentation as to reason.

Legal Reference:

18 NYCRR 432.13 (e)(2) (vi) & (vii)

Action:

MCDHS will document the reason for keeping a FAR case open more than 90-days and also document the goals of working with the family as well as steps that will be taken to attain these goals. MCDHS will offer Preventive services to families when a need is identified.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/20/2016	Sibling, Female, 10 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 10 Years	Mother, Female, 34 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:

The SM was not providing an adequate amount of food for the SS and as a result the child was going hungry and missing meals on a regular basis. The SS did not have any seasonally appropriate clothing that fit. The SM was not bathing the SS on a regular basis, and as a result she had a foul body odor. The home was in deplorable condition, with animal feces and garbage strewn around. The home was cluttered with no clear paths to the exits, making it a safety hazard. On unknown dates, mother had parties in the home for money. There were dangerous people who have shot their weapons outside the home at the parties, putting the SS at risk of harm.

Determination: Unfounded | **Date of Determination:** 07/08/2016

Basis for Determination:
MCDHS met with the SM, BF, MGM and SS. All parties denied a shortage of food or clothing for the SS. The SM reported having social gatherings at the home occasionally, but denied anyone ever shot a gun outside the home during the parties. MCDHS found the SS to be clean and have appropriate clothing. The home was not found to have any safety concerns.

OCFS Review Results:
MCDHS met with the SM, BF, MGM and SS regarding the concerns in the report. Collateral contact was made with the SS school and no concerns were noted. MCDHS offered assistance to the SM. FAR was offered to the family and they accepted. The FAR approach was used and documented, but the case was never tracked to FAR and was determined as an investigation. It was very unclear why FAR was agreed upon but the process never completed. The RAP was not completed accurately and the BF never received a notice of existence letter.

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

Issue:
Failure to provide notice of report
Summary:
The BF was living in the home and listed on the report, but never sent a notice of existence letter.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
MCDHS will provide notice of existence of a report letters to all adults listed on the report.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The BF was not listed as a secondary caretaker on the RAP, although he was living in the home and caring for the SS. As a result, several questions were inaccurately answered on the RAP.
Legal Reference:
18 NYCRR 432.2(d)
Action:
MCDHS will appropriately identify and add all caretakers on the RAP. MCDHS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/15/2016	Sibling, Female, 10 Years	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Far-Closed	Yes
	Sibling, Female, 10 Years	Mother, Female, 35 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 10 Years	Mother, Female, 35 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 10 Years	Father, Male, 41 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 10 Years	Father, Male, 41 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 10 Years	Father, Male, 41 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
An SCR report was received alleging the SM and BF were regularly using cocaine in the presence of the SS. The report stated the dogs living in the home urinated and defecated throughout the home and the house had a foul odor. The report further alleged the SS was not regularly bathing and had a foul body odor as a result. The SM and BF were regularly impaired by cocaine when caring for the SS.

OCFS Review Results:
MCDHS contacted the source and completed the safety and risk assessments. MCDHS met with everyone listed on the report and explained and documented the FAR approach, including completing the FLAG. Collateral contacts were made with the SS's pediatrician and school and no concerns were noted. New concerns that arose during the open case were promptly addressed with the SM, MGM and BF.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP question regarding a caretaker having a diagnosed disability was answered inaccurately. The SM received disability payments and this was not fully explored.

Legal Reference:
18 NYCRR 432.2(d)

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/23/2015	Other Child - OC, Female, 12 Years	Other Adult - BF to OC, Male, 25 Years	Excessive Corporal Punishment	Unfounded	Yes
	Other Child - OC, Female, 12 Years	Other Adult - BF to OC, Male, 25 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:
An SCR report was received alleging the BF hit the OC with a belt as punishment for fighting with her siblings. The OC had faint bruising on her leg as a result of the BF's actions.

Determination: Unfounded **Date of Determination:** 03/28/2016

Basis for Determination:
The OC reported the BF hit her on the leg with a belt and the BF denied it. The BF stated he hit the OC with an open hand on the buttocks for drawing inappropriate pictures. MCDHS interviewed family members and they reported the OC had self-injurious behaviors and was manipulative. The OC's siblings denied anyone in the home was hit with a belt.

OCFS Review Results:
MCDHS contacted the source, sent notice of existence to the BF and BM, and interviewed collaterals. The OC and her 3 siblings were interviewed. A fourth sibling to the OC was seen and safe sleep discussed. The safety and risk assessments were completed accurately. There were issues that arose during the investigation that were appropriately addressed with the BM and BF and resolved.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:

The 7-day safety assessment was completed 3 days late.

Legal Reference:

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

Action:

Within seven days of receiving a report, MCDHS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/08/2015	Other Child - OC, Female, 11 Years	Other Adult - BM to OC, Female, 27 Years	Inadequate Guardianship	Unfounded	No
	Other Child - OC, Female, 11 Years	Other Adult - BM to OC, Female, 27 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:

An SCR report was received alleging the BM hit the OC after becoming angry with her. The BM used her hand and also an unknown object. The OC had bruising to her left arm as a result of being hit.

Determination: Unfounded **Date of Determination:** 04/29/2015

Basis for Determination:

MCDHS found no credible evidence to substantiate the allegations against the BM regarding the OC. The OC had a small bruise on her arm and reported her mother hit, pinched and bit her to cause it. MCDHS found the bruise was inconsistent with the OC's report. The OC's sibling said the BM did hit the OC on the arm but the OC's 2 other siblings had no knowledge of this. The OC and her 3 siblings all denied the BM ever used an object to hit them, they did report at times she would hit them with an open hand. The OC had a history of hitting herself. MCDHS cautioned the BM about physical discipline before closing the investigation.

OCFS Review Results:

MCDHS interviewed the SM, the OC and her 3 siblings separately regarding the allegations. NOE's were sent to the BF of the 3 eldest OC and the BF of the youngest OC. The safety and risk assessments were completed timely and accurately. MCDHS made appropriate collateral contacts.

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

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

History regarding the SM, BF of SC and SS:
2/13/07-3/27/07-L/B/W and IG Sub against BF of SC regarding SS.
3/19/08-5/19/08-IG, XCP, L/B/W against BF of SC regarding 3 SS.
4/6/09-5/22/09-LS and IG Sub against the SM regarding the SS.
7/17/09-9/14/09-LS and IG Sub and IF/C/S Unsub against SM regarding the SS.
4/5/10-5/26/10-IF/C/S, IG, LS and PD/AM Unsub against the SM regarding the SS.
3/30/11-5/12/11-IF/C/S and IG Unsub against SM regarding the SS.
7/2/11-9/15-11-PD/AM and IG Sub against SM regarding SS.
4/22/13-5/30/13-IG Unsub against SM regarding SS.
7/11/14-9/25/14-IF/C/S, PD/AM, L/B/W and IG Unsub against SM regarding SS.

History regarding OC:
2/2/10-4/26/10-IG, XCP Unsub against BM regarding OC.
9/29/10-12/17/10-L/B/W and IG Unsub against BM regarding OC.
1/3/11-4/14/11-XCP, L/B/W and IG Unsub against BM regarding OC.

5/2/11-7/1/11-L/B/W and IG Unsub against BM regarding OC.
11/28/11-12/30/11- FAR case with BM and OC as recipients.
5/17/12-9/7/12-FAR case with BM and OC as recipients.
6/17/14-8/15/14-FAR Case with BM and OC as recipients.

Known CPS History Outside of NYS

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

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

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