Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-18-019

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

Issue Date: Oct 11, 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: 0 day(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 06/01/2018
Initial Date OCFS Notified: 06/07/2018

Presenting Information

On 6/1/2018, Monroe County Department of Human Services (MCDHS) was informed of the death of the SC. The SC was born on this date at 10:55AM, and died approximately six hours later. The SC was born with medical anomalies that were not compatible with life; he was born without kidneys and had seriously underdeveloped lungs. The SC was one of two children borne by the BM on this date as part of a multiple birth; the surviving child was born without medical complications. Though MCDHS was aware the BM had used illicit drugs during her pregnancy, MCDHS was informed by medical staff that the SC's anomalies did not have anything to do with the BM's prenatal drug use.

Executive Summary

This fatality report concerns the death of the SC, who passed away during an open CPS investigation. The SC and his twin brother were born on the date of an SCR report, 6/1/2018. The report alleged the BM and the SC's twin sibling tested positive for an illicit drug, and noted the SC was not tested, as he was born with anomalies that were not compatible for life.

Through contacts with collaterals at the hospital where the children were born, MCDHS discovered the BM learned early on in her pregnancy that the SC had not developed kidneys and would not survive after birth. Staff informed when babies do not develop kidneys in utero, their lungs do not develop either; therefore, the death was expected. The BM had been offered selective termination of the SC during her pregnancy, though she chose to carry both children to term. The BM gave birth to the twins after 36 weeks of pregnancy. When MCDHS arrived at the hospital in response to the SCR report, it was learned the SC had died. He was alive for approximately 6 hours. Based on the information MCDHS gathered, there was no reason to suspect the cause of death was a result of abuse or maltreatment.

MCDHS notified the Rochester Regional Office of the SC's death and proceeded with an investigation into the allegations concerning the surviving twin. MCDHS facilitated a protective removal of the newborn twin in response to current and historical concerns for the BM's ability to care for children. MCDHS assessed the safety of the other 3 surviving siblings, none of whom were in the primary care or custody of the BM. No concerns were revealed for them. Their caregivers allowed rare contact between the children and the BM, due to their knowledge of ongoing concerns for the BM.

MCDHS obtained a copy of the Death Certificate, which noted the manner of death was a "natural cause," and indicated the case was not referred to a Medical Examiner as an autopsy was refused. MCDHS made multiple efforts to obtain written medical documentation from the hospital, but were unsuccessful. MCDHS relayed to OCFS during this review that requests for those documents would continue to be made.

MCDHS closed the CPS investigation that was open at the time of the fatality and opened a Foster Care Services case on 6/14/18. That case remained open at the time this report was written.

PIP Requirement

For issues identified in historical cases, MCDHS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
The above questions are not applicable as the fatality was not reported to the SCR. There was no report alleging the fatality was suspected to be a result of abuse or maltreatment by a caretaker; however, other decisions made during the open investigation were appropriate.

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 decision to close the investigation was appropriate. Prior the investigation closing, a Foster Care Services case was opened, and remained open at the time this report was written.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/01/2018 **Time of Death:** 05:31 PM

Time of fatal incident, if different than time of death: 10:55 AM

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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: Hospitalized after birth

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	0 Day(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Male	0 Day(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	57 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	52 Year(s)
Other Household 1	Sibling	No Role	Male	11 Year(s)
Other Household 2	Sibling	No Role	Male	9 Year(s)
Other Household 3	Sibling	No Role	Female	5 Year(s)

LDSS Response

MCDHS responded to the hospital upon receiving an SCR report concerning the SC's twin brother. It was then that MCDHS learned the SC had passed away. It was confirmed the death was expected, and medical staff informed the SC's death did not have anything to do with the BM's drug use during pregnancy. For this reason, there was no SCR report made alleging the death was a result of abuse or maltreatment, and MCDHS appropriately notified their Regional Office that the child died during an open investigation.

MCDHS interviewed the BM and documented her understanding of the safety concerns (her history and the baby's positive toxicology) and why the surviving newborn twin was not safe returning to her care after discharge from the hospital. The BM identified resource persons to care for the surviving child - the adults she resided with at the onset of the investigation - but MCDHS found they were not appropriate to care for him. The BM was not certain who the children's biological father was. MCDHS learned the BM moved in with a man whom the BM identified was one of two prospective fathers; however, MCDHS' efforts at a home visit to engage them in planning for his alternative care arrangements was unsuccessful. A removal without consent ensued, and the matter was brought to Family Court. A Foster Care Services case was subsequently opened.

During the open investigation, MCDHS contacted two relatives who were separate custodians of two of the older surviving siblings. MCDHS learned both caregivers allowed minimal to no contact between the children and the BM, due to their knowledge of ongoing concerns. MCDHS attempted to contact the biological father/custodian of the third surviving sibling, though efforts were unsuccessful. MCDHS documented in their history review knowledge of an active Order of Protection, prohibiting contact between that child and the BM.

During the open Foster Care Services case, the surviving twin had reportedly made a positive adjustment to his Foster Care setting of a long-term foster home. Barriers were noted regarding the BM's failure to communicate or plan with MCDHS. MCDHS discussed sleep safety with the foster parent. MCDHS continued efforts to engage the BM in the provision of services during the Foster Care Services case, which remained open at the time this report was written.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The fatality was reviewed by the Monroe County Child Fatality Review Team in August, 2018.

CPS Fatality Casework/Investigative Activities

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

Additional information:
The safety assessment of the infant SS was not documented until 11 days after the open investigation began. An effort was made to visit the home where BM moved, but MCDHS was unsuccessful. The older SS were not interviewed, given the circumstances.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☐	☒	☐
At 7 days?	☐	☐	☒	☐

At 30 days?	☐	☐	☒	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐
Explain: The 24-Hour and 30-Day Safety Assessments were not required as the fatality was not reported to the SCR. The 7-day safety assessment was completed and accurate, but was 4 days late. Since the fatality was not reported to the SCR, the late 7-Day Safety Assessment was noted under review of CPS history.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: Due to the multitude of concerns for the BM, Foster Care Services were needed as well as an array of other services to address those concerns. A Foster Care Services case was opened on 6/14/18.				

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 newborn surviving sibling was removed as a result of concerns for the BM's ability to care for him. Other siblings were established in other custody arrangements and had been for an extended period, not in the custody of the BM, due to CPS concerns.

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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:
Several services were planned to be offered to the BM in the open Foster Care Services case, though the BM became unable to be located and communicated limitedly during the case. Though MCDHS was in contact with the BM following the fatality, it did not appear any fatality-related services were discussed. MCDHS provided services to the child in care, and continued efforts to engage the BM.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
There were no identified service needs for the siblings in response to the fatality, though Foster Care Services were provided to the newborn sibling in response to concerns in the open CPS case.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The record did not reflect any fatality-related services were offered to the BM; however, she was minimally cooperative during the investigation and subsequent Foster Care Services case. Her whereabouts were often unknown, and it appeared from the record mailing information would not have been successful.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	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 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)	Allegation Outcome	Compliance Issue(s)
06/01/2018	Sibling, Male, 5 Hours	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 5 Hours	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report alleged the BM gave birth on this date to twin boys. The BM's toxicology screen came back positive for

cocaine and marijuana. One of the twin boys' toxicology report came back positive for cocaine. The other twin infant (the SC) was not tested because he was born with anomalies that were not compatible for life. His anomalies did not have anything to do with the BM's drug use during her pregnancy, and were discovered in an earlier ultra sound. The BM did not have provisions to care for the surviving son. The roles of the two unrelated home members, the BM's godparents, were unknown.

Report Determination: Indicated | **Date of Determination:** 06/20/2018

Basis for Determination:
MCDHS found some credible evidence that the BM placed the newborn SS at risk of harm. MCDHS documented BM's substantial history with drug use and its impact on her ability to care for children; her other children remained out of her care and visited her rarely due to these and other concerns. There was also an OP against BM protecting one of the siblings. The BM admitted to using drugs during her pregnancy and the day before she gave birth. The newborn SS did not experience withdrawal symptoms, but had an extended stay in the hospital after birth due to being born premature. The SS was removed without the BM's consent upon his discharge from the hospital, and a Foster Care case was opened.

OCFS Review Results:
MCDHS appropriately determined the imminent safety concerns to the newborn sibling and took protective actions when necessary. MCDHS thoroughly documented the BM's history as it pertained to other surviving siblings, as well as how the history was a substantial basis for the safety and risk to the newborn. MCDHS notified OCFS upon the death of the SC, who died on the day this report was made.

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 4 days late.

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

Action:
MCDHS will complete all safety assessments in accordance with statutory requirements.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/08/2017	Sibling, Male, 8 Years	Other Adult - Friend of SS2's PGM, Female, 55 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 8 Years	Other Adult - SS2's PGM, Female, 54 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged SS2, age 8, had access to the marijuana of SS2's PGM and her friend, located on their patio, from a party over the weekend of May 6-7, 2017. The marijuana was in a jar and SS2 brought the drugs to school. The role of the other child, SS2's sibling, was unknown.

Report Determination: Unfounded | **Date of Determination:** 07/11/2017

Basis for Determination:
SS2's PGM was the legal guardian of SS2 and his sibling. Her friend lived in the home and was noted as a person legally responsible for the children's care. MCDHS determined SS2 did bring marijuana to school, but when interviewed, he stated he found it at the bus stop. The adults admitted there had been a party, but stated no children were present, and there was no use of illegal drugs. The adult friend/caregiver was out of the state at the time the party was held. When interviewed, the CHN denied anyone in the home used marijuana, and there was no evidence found that SS2 got the marijuana from the home.

OCFS Review Results:
MCDHS conducted a thorough investigation, addressing the alleged concerns as well as other areas of potential child welfare concern. MCDHS made attempts to speak with all absent parents, and contacted both CHN's mothers, but not their BF, despite efforts. MCDHS satisfactorily completed all other required casework activity.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/03/2016	Sibling, Female, 3 Years	Other Adult - SS3's BF, Male, 57 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 3 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Other Adult - SS3's BF, Male, 57 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged BM abused crack and alcohol and SS3's BF abused alcohol and marijuana while in the presence of the 3yo SS (SS3). The adults were unable to care for SS3 while intoxicated. BM would drive with SS3 while under the influence, and would bring the child to drug houses. There was an OP that the BM was not supposed to have contact with SS3.

Report Determination: Unfounded **Date of Determination:** 01/10/2017

Basis for Determination:
MCDHS determined there was no credible evidence to substantiate the allegations. Both parents denied the allegations, and a collateral contact (SS3's BF's friend) corroborated prior to SS3's BF being interviewed. At each contact, MCDHS did not observe SS3's BF to be under the influence of any substances. The parents confirmed there was an active Stay-Away Order of Protection against BM for SS3 and the parents stated they complied with this order. MCDHS made ongoing assessments of the SS and found her to be protected with her BF and adequately cared for.

OCFS Review Results:
MCDHS addressed the allegations and made all appropriate contacts. When CW observed BM to be under the influence of drugs, treatment was offered to her, but she declined. The 7-day Safety Assessment was 19 days overdue and the CPS history check was not completed within the required timeframe.

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

Issue:
Review of CPS History
Summary:
The review of CPS history was documented as having been completed on the twelfth day of the investigation.

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

Action:
Within one business day, MCDHS will review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded reports where the current report involves a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report. The history check should be documented in progress notes accordingly.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/13/2016	Sibling, Female, 3 Years	Other Adult - SS3's BF, Male, 57 Years	Burns / Scalding	Unsubstantiated	Yes
	Sibling, Female, 3 Years	Other Adult - SS3's BF, Male, 57 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Other Adult - SS3's BF, Male, 57 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Other Adult - SS3's BF, Male, 57 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged SS3's BF abused alcohol and cocaine to impairment while caring for her. About 1 year prior, he was failing to supervise SS3 while he was partying. As a result, SS3 pulled down a hot iron, causing it to hit her left hand. SS3 sustained a severe burn to the area, which later became scarred. SS3's BF never sought medical care for the injury. He also regularly hit SS3. The month prior, he hit her (while holding a beer) then SS3 ran away from him and into the road, almost getting hit by a car. SS3's BF would leave beer within reach of her, and she had tried to drink it, which her BF found funny. Her BF exposed her to adults who came to the home, who used drugs around SS3.

Report Determination: Unfounded | **Date of Determination:** 06/29/2016

Basis for Determination:
MCDHS learned information from SS3's BF about the alleged incidents. He stated 1 year prior he was ironing and walked away for a moment, when SS3 pulled the iron down and sustained a "little" burn, not requiring medical attention. MCDHS observed SS3's hands and did not observe a scar. SS3's BF noted a time he was crossing the street with SS3 when she pulled away and proceeded to run across the road, to which he responded by "popping her on the butt" and telling her what she did wrong. He also denied SS3 had tried to drink beer or that he had any drug users around his home. No concerns were revealed from collateral contacts.

OCFS Review Results:
MCDHS addressed allegations and other areas of potential child welfare concern with SS3's BF. MCDHS noted observations that SS3's BF appeared sober during contacts. Efforts were made to engage SS3 in an interview, but she refused. Observations of the alleged injury were documented; however, progress notes revealed a scar was observed on SS3's hand, and the investigation conclusion noted that no scar was seen. Two questions were answered inaccurately in the RAP, greatly affecting the overall score.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
Two questions were answered wrong on the RAP – It did not reflect the history of SS3's BF engaging in physical disputes with BM two years prior. The elevated risk element regarding siblings being removed who continue to reside with alternate caregivers was answered as "no," though that was inaccurate.

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.

[redacted]

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

6/21/14-8/12/14 UNF for PD/AM and IG against SS3's BF regarding SS3.

2/2/14-4/15/14 IND for II, IG, S/D/S, PD/AM, and L/B/W against BM regarding SS3. Three total SCR reports were made, consolidated into 1 investigation. SM was arrested for assaulting the infant SS; SS3 was released to the care of her BF upon issuance of a criminal OP for SS3 against BM. Service referral made, but declined.

11/1/13-1/7/14 UNF for IG against BM and SS3's BF regarding SS1 and SS3. Service referral made, but declined.

6/3/13-8/1/13 IND for PD/AM and IG against BM regarding SS3. BM and SS3 tested positive for marijuana upon SS3's birth.

6/23/12-7/20/12 UNF for IG and IF/C/S against BM and MA regarding SS1.

11/1/11-2/9/12 UNF for IG, PD/AM, and SA against SS2's BF and PGM regarding SS2, as well as L/B/W against SS2's PGM.

11/16/09-12/7/09 UNF for IG, PD/AM, and LS against SS2's BF regarding SS2.

9/28/09-11/4/09 UNF for IG, IF/C/S, LS, LMC, and L/B/W against SS2's BF regarding SS2. A subsequent report on 10/13/09 was consolidated into this investigation.

8/27/08-10/8/08 IND for IG and PD/AM against BM regarding SS2. SS2 was removed from BM and placed in foster care until a relative (MA) could be approved for placement. SS1 was noted as already being in the care and custody of MA, prior to this report.

Known CPS History Outside of NYS

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

Foster Care Placement History

On 8/29/08, the BM's second child (SS2) was placed into foster care when he was born 2 days prior with a positive toxicology for drugs. In addition to the BM's poly substance use, there were also concerns for BM's unstable housing and lack of supplies for the new baby. Initially the child was placed in a foster home until 9/5/08, at which time custody was transferred to a relative (maternal aunt) under the supervision of MCDHS. This relative already had custody of BM's eldest child. MCDHS recommended inpatient substance treatment, parenting classes, and supportive housing; however, the BM did not successfully complete all goals. MCDHS assisted with supervised visitation with BM and the child. The maternal aunt and both children were named in the case, and the aunt assisted with the development of the service plan.

The BM expressed interest in her sister obtaining custody of SS2, and the aunt obtained permanent custody on 1/9/09. As the child had obtained permanency, the Foster Care Services case closed.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/14/2018	There was not a fact finding	Foster Care Placement to Continue
Respondent:	046882 Mother Female 33 Year(s)	
Comments:	MCDHS facilitated a protective removal of the newborn surviving twin on 6/12/2018, without the BM's consent, as she failed to meet to plan for the child. At a hearing on 6/14/2018, the BM failed to appear and the Family Court Judge granted Foster Care Placement to continue for the child. Court activity remained ongoing.	

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