Child Fatality Report

Report Identification Number: AL-19-012

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

Issue Date: Sep 09, 2019

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Rensselaer
Gender: Female
Date of Death: 03/09/2019
Initial Date OCFS Notified: 03/11/2019

Presenting Information

An SCR report was received with concerns on 3/9/19, the mother and 1-month-old child were asleep together in the same bed. The report alleged at 7:30 AM, the grandmother checked on the mother and child, and found the mother asleep with her arm extended across the child; the child was unresponsive. The grandmother contacted 911 and the child was transported to the hospital where she was pronounced deceased.

Executive Summary

This fatality report concerns the death of a 1-month-old female subject child (SC) that occurred on 3/9/19. A report was made to the SCR on 3/10/19, with allegations of Inadequate Guardianship and DOA/Fatality against the child's 15-year-old mother (SM) and the child's maternal grandmother (MGM). An autopsy was completed and noted both the cause and manner of death as undetermined with a "history of possible overlay."

Rensselaer County Department of Social Services (RCDSS) had been involved with the family since 3/5/19 after an SCR report was received with allegations unrelated to those in the fatality report. At the time of the child's death, she resided with her mother, grandmother, an adult maternal aunt, a minor maternal aunt and three minor maternal uncles, ages: 12 (MA), 10 (UA1), 8 (UA2) and 5(UA3). The child's biological father (BF), who was also 15-years-old, did not live in the home, nor was he present on the date of the incident. According to the child's pediatrician, the child was up to date medically and there were no concerns regarding her health. It was discovered at approximately 3:45 AM on 3/9/19, the mother had just finished feeding the child and laid the child back in bed with her to sleep; the mother would regularly co-sleep with the child. At around 7:30 AM, the grandmother entered the mother's room and found the mother asleep in bed, with her arm extended out onto the back of the child's neck. The child was face down in a pillow and unresponsive. A family member who had stayed the night began CPR on the child while the grandmother called 911. Emergency services arrived shortly thereafter and transported the child to the hospital. The child was declared deceased at 8:27 AM on 3/9/19.

From the time the investigation began to the time of its closure, RCDSS met with and interviewed all household members, the child's biological father, and several collateral sources. There were numerous concerns found regarding the grandmother's ability to provide a stable environment for her children and control their behaviors. This resulted in the children, including the child's mother, being placed into foster care. The fatality investigation was not yet determined at the time of this writing, and a services case was opened and remained ongoing.

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

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 fatality investigation had not yet been determined 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 casework activity was commensurate of the case circumstances, and the decision to file a petition and open the case for CPS services was appropriate.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Many progress notes were entered more than one month past their event dates.
Legal Reference:	18 NYCRR 428.5
Action:	RCDSS will enter progress notes contemporaneously as events occur.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/09/2019 **Time of Death:** 08:27 AM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Rensselaer
Was 911 or local emergency number called? Yes
Time of Call: 07:52 AM
Did EMS respond to the scene? Yes

At time of incident leading to death, had child used alcohol or drugs? No

Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes

How long before incident was the child last seen by caretaker? 2 Hours

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	Aunt/Uncle	No Role	Male	10 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	12 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	8 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	5 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	39 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	15 Year(s)
Deceased Child's Household	Other Adult - Other Family Member	No Role	Female	21 Year(s)
Other Household 1	Father	No Role	Male	15 Year(s)
Other Household 2	Grandparent	No Role	Male	51 Year(s)
Other Household 3	Grandparent	No Role	Male	50 Year(s)

LDSS Response

On 3/10/19, RCDSS received an SCR report regarding the death of the SC, which occurred on 3/9/19. RCDSS had been involved with the family since 3/5/19, after receiving an SCR report with concerns unrelated to SC's death. RCDSS made efforts to engage the family regarding the initial SCR report; however, the family was uncooperative. RCDSS spoke with SM and MGM on 3/6/19, and observed SC to appear safe. Also at that time, RCDSS reviewed safe sleep practices, but MGM denied RCDSS access to the home to observe provisions. RCDSS made additional attempts to meet with the family in the days preceding the fatality report. When the fatality report was received, RCDSS coordinated with LE. It was learned SM and her 4 siblings, ages 5, 8, 10, and 12 years old, resided in the home with SC, MGM, and OA; the family had an extensive CPS history. RCDSS promptly began efforts to assess the safety of all the CHN in the household.

On 3/10/19, RCDSS and LE completed a home visit to the family's residence; SM was not present. RCDSS observed the

other CHN to be safe. RCDSS spoke with MGM about the fatality. MGM stated SC was acting normally on 3/8/19, and went to bed with SM around 11:00 PM that night. MGM stated SC typically slept in bed with SM. MGM reported on the morning of 3/9/19, she went into SM's room at approximately 7:30 AM to check on SC, as that is the time SC usually woke up to be fed. MGM reported when she walked in, SM was asleep on her back with her arm extended out, and SC was face down in a pillow with SM's arm across the back of her neck. MGM stated she woke SM and SC was not breathing; MGM called 911 while a family member who had spent the night began CPR. MGM denied SC had any medical issues and saw her pediatrician regularly. MGM stated SM had prenatal care as well. RCDSS observed the bed where SC was found unresponsive; it was a queen-sized mattress placed on the floor. A Pack 'N Play was also observed in the bedroom. RCDSS did not note any concerns surrounding the home environment on the date of this contact.

A scheduled home visit took place on 3/13/19 where MGM and SM were interviewed. MGM reported on the night of SC's death, the other CHN were asleep. SM reported she went to bed with SC at 11:00 PM, and woke up from 3-3:45 AM to feed SC; she and her sibling were taking videos and pictures of SC while she had her bottle. SM reported she went back to sleep with SC next to her at around 5:00 AM, and was awoken by MGM. SM stated that is when SC was found face down and unresponsive. SM stated SC would normally sleep on her back or stomach, but preferred to sleep on her stomach. SM reported SC was acting normally the day of her death and had recently seen her pediatrician for a checkup. On 3/15/19, RCDSS met with BF in his home. BF was not present on the date of SC's death and denied any concerns for SM or MGM. BF had no other information.

On 3/19/19 and 3/27/19, RCDSS interviewed the other CHN in the household at their schools. The three younger CHN did not express any safety concerns and had no information surrounding SC's death. The 12yo MA reported she was asleep in bed with SM and SC when SC was found not breathing. MA stated she had slept in the bed with them in the past, as well. MA's story was consistent with that of SM and MGM, and she expressed no safety concerns for herself or any of the other CHN in the home.

Throughout the investigation, RCDSS spoke with collateral sources including medical, schools, and first responders. RCDSS offered the family appropriate services in response to SC's death, and there were no charges brought against SM or MGM by LE. While investigating the fatality, several concerns unrelated to SC's death arose that led to the removal of all the CHN in the household. The CHN were placed in foster care, a Neglect Petition was filed in Family Court, and a services case was opened. Additionally, the fatality investigation was not yet determined at the time of this writing.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: This fatality investigation was conducted by the Rensselaer County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Rensselaer County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

051060 - Deceased Child, Female, 1 Month(s)	051042 - Grandparent, Female, 39 Year(s)	DOA / Fatality	Pending
051060 - Deceased Child, Female, 1 Month(s)	051041 - Mother, Female, 15 Year(s)	DOA / Fatality	Pending
051060 - Deceased Child, Female, 1 Month(s)	051042 - Grandparent, Female, 39 Year(s)	Inadequate Guardianship	Pending
051060 - Deceased Child, Female, 1 Month(s)	051041 - Mother, Female, 15 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐
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:
RCDSS spoke with all appropriate collateral sources throughout the investigation.

Fatality Safety Assessment Activities

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

Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
Concerns that arose during the fatality investigation led to all of the CHN being removed and placed into foster care. A CPS services case was opened and ongoing at the time of this writing.

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:
Concerns surrounding MGM's inability to maintain stable, appropriate housing arose during the fatality investigation, as well as ongoing concerns surrounding the CHN's school attendance and MGM's ability to manage the CHN's behaviors. As a result, the CHN were placed into foster care.

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:**
06/14/2019	There was not a fact finding	Adjourned
Respondent:	051042 Grandparent Female 39 Year(s)	
Comments:	There were concerns that arose during the fatality investigation that included MGM's inability to maintain stable housing, ensure her CHN went to school, and control their behaviors. These concerns led to all of the CHN being removed and placed into foster care. A petition was also filed against the CHN's biological father, as he was also unable/unwilling to provide for his CHN. A CPS services case was opened and ongoing at the time of this writing.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/14/2019	There was not a fact finding	Adjourned
Respondent:	051048 Grandparent Male 51 Year(s)	
Comments:	There were concerns that arose during the fatality investigation that included MGM's inability to maintain stable housing, ensure her CHN went to school, and control their behaviors. These concerns led to all of the CHN being removed and placed into foster care. A petition was also filed against the CHN's biological father, as he was also unable/unwilling to provide for his CHN. A CPS services case was opened and ongoing at the time of this writing.	

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: CPS Services Case Opened

Additional information, if necessary:
Appropriate services were offered in response to SC's death. The record did not reflect if family planning was discussed with MO or MGM. Concerns that arose during the fatality investigation led to all of the CHN being removed and placed into foster care. A CPS services case was opened and ongoing at the time of this writing.

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:
Appropriate services were offered in response to SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Appropriate services were offered in response to SC's death. Due to other concerns, the CHN were placed into foster care and a CPS services case was opened.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
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)	Allegation Outcome	Compliance Issue(s)
03/05/2019	Deceased Child, Female, 1 Months	Mother, Female, 15 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
This report was received with concerns SM got into numerous physical altercations with other peers in the presence of SC. The report alleged one of the altercations occurred on 3/3/19, and SM had a knife as a weapon.

Report Determination: Unfounded | **Date of Determination:** 08/01/2019

Basis for Determination:
RCDSS spoke with SM and MGM regarding the allegations in the report and spoke with one of the responding officers from the alleged altercation. The family was not cooperative with the CPS investigation. During this investigation, SC passed away and all of MGM's CHN, including SM, were placed into foster care.

OCFS Review Results:
Many progress notes were entered more than one month past their event dates. The 7 Day Safety Assessment was submitted and approved one day late. Interviews with the CHN were completed and documented in the fatality investigation; however, the notes were not copied into this case.

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 one day late.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Within seven days of receiving a report, LDSS 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.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Many progress notes were entered more than one month after event dates. Although interviews with the CHN occurred and were documented in the fatality investigation, the interviews were not documented in this investigation.
Legal Reference:
18 NYCRR 428.5
Action:
RCDSS will enter progress notes contemporaneously as events occur, including carrying over notes which reflect duplicate casework completed in concurrent investigations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/13/2018	Aunt/Uncle, Female, 11 Years	Other - MGM, Unknown, 38 Years	Educational Neglect	Substantiated	Yes

	Mother, Female, 14 Years	Other - MGM, Unknown, 38 Years	Educational Neglect	Unsubstantiated

Report Summary:
This report was received by Dutchess County Department of Social Services (DCDSS) with concerns the children were not attending school and were in danger of failing. The family was found to be residing in Rensselaer County, therefore primary jurisdiction was transferred to RCDSS.

Report Determination: Indicated | **Date of Determination:** 02/05/2019

Basis for Determination:
RCDSS met with MGM and the CHN, and obtained information from the CHN's schools. During this investigation, the family secured an apartment and SC was born. By the conclusion of the investigation, the CHN were still not attending school regularly. RCDSS indicated the report, referred the family to community-based services and closed the case.

OCFS Review Results:
There were no efforts to have the biological father interviewed at the prison where he was incarcerated. A legal consultation regarding continued concerns was not completed to determine if further Family Court action was necessary.

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

Issue:
Face-to-Face Interview (Subject/Family)

Summary:
One of the CHN's biological fathers was incarcerated and the location was known to RCDSS. The record does not reflect any attempts to have the father interviewed.

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

Action:
RCDSS will make efforts to interview all persons named in a report, face to face, who may have been present during what was alleged in the report, and/or may have information pertinent to the safety and well-being of children that reside in the home, including absent biological parents.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/08/2018	Mother, Female, 14 Years	Other - MGM, Female, 38 Years	Educational Neglect	Substantiated	Yes
	Mother, Female, 14 Years	Other - MGM, Female, 38 Years	Inadequate Guardianship	Substantiated	

Report Summary:
This report was received with concerns SM missed numerous days of school and was failing as a result. The report alleged MGM was aware and the school referred her to PINS for SM; however, MGM never followed through.

Report Determination: Indicated | **Date of Determination:** 08/08/2018

Basis for Determination:
RCDSS spoke with MGM and the CHN regarding the concerns. MGM reported she could no longer control SM's behaviors; however, did not follow through with PINS or enrolling SM in summer school. SC was pregnant during this investigation. RCDSS indicated and closed the case; the family remained involved in an open services case.

OCFS Review Results:
Many progress notes were not entered contemporaneously. There were no attempts to speak with the biological fathers of the CHN.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Many progress notes were entered more than one month past event dates.
Legal Reference:
18 NYCRR 428.5
Action:
RCDSS will enter progress notes contemporaneously as events occur.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
There were no attempts to speak with one of the biological fathers of the CHN.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
RCDSS will make efforts to interview all persons named in a report, face to face, who may have been present during what was alleged in the report, and/or may have information pertinent to the safety and well-being of children that reside in the home, including absent biological parents.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/02/2018	Mother, Female, 13 Years	Other - MGM, Female, 37 Years	Educational Neglect	Substantiated	Yes

Report Summary:
This report was received by Albany County Department for Children, Youth, and Families (ACDCYF) with concerns SM was missing school and excessively tardy; SM was failing as a result. The report alleged MGM was contacted on several occasions regarding the absences, but had failed to address the concerns.

Report Determination: Indicated | **Date of Determination:** 02/05/2018

Basis for Determination:
ACDCYF interviewed MGM and the CHN and obtained attendance records from SM's school. SM was failing all of her classes. The Neglect Petition and the family's open services case were transferred via a Change in Venue petition through Rensselaer County Family Court. ACDCYF opened a services case for the family in Albany County to continue addressing concerns.

OCFS Review Results:
The RAP was inaccurate. Notice of Existence Letters were mailed/delivered two days late. There were no attempts to interview the biological fathers of the children.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP was completed inaccurately: The question surrounding recent unstable housing should have been answered "yes," and the question surrounding abusive or threatening incidents with partners should have been answered "yes."
Legal Reference:
18 NYCRR 432.2(d)
Action:

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

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
The case record did not reflect any efforts to interview the children's biological fathers.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
ACDCYF will make efforts to interview all persons named in a report, face to face, who may have been present during what was alleged in the report, and/or may have information pertinent to the safety and well-being of children that reside in the home, including absent biological parents.

Issue:
Failure to provide notice of report
Summary:
Notice of Existence letters were mailed/delivered 2 days late.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACDCYF will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/24/2017	Aunt/Uncle, Male, 8 Years	Grandparent, Female, 37 Years	Lack of Medical Care	Substantiated	No
	Mother, Female, 13 Years	Grandparent, Male, 48 Years	Lack of Medical Care	Unsubstantiated	
	Aunt/Uncle, Female, 10 Years	Grandparent, Male, 48 Years	Lack of Medical Care	Unsubstantiated	
	Aunt/Uncle, Male, 8 Years	Grandparent, Male, 48 Years	Lack of Medical Care	Unsubstantiated	
	Aunt/Uncle, Male, 7 Years	Grandparent, Male, 48 Years	Lack of Medical Care	Unsubstantiated	
	Mother, Female, 13 Years	Grandparent, Male, 48 Years	Educational Neglect	Unsubstantiated	
	Mother, Female, 13 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Aunt/Uncle, Female, 10 Years	Grandparent, Male, 48 Years	Educational Neglect	Unsubstantiated	
	Aunt/Uncle, Female, 10 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Aunt/Uncle, Male, 8 Years	Grandparent, Male, 48 Years	Educational Neglect	Unsubstantiated	

Aunt/Uncle, Male, 8 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Unsubstantiated
Aunt/Uncle, Male, 7 Years	Grandparent, Male, 48 Years	Educational Neglect	Unsubstantiated
Aunt/Uncle, Male, 7 Years	Grandparent, Male, 48 Years	Inadequate Guardianship	Unsubstantiated
Mother, Female, 13 Years	Grandparent, Female, 37 Years	Educational Neglect	Substantiated
Mother, Female, 13 Years	Grandparent, Female, 37 Years	Inadequate Guardianship	Substantiated
Aunt/Uncle, Female, 10 Years	Grandparent, Female, 37 Years	Educational Neglect	Substantiated
Aunt/Uncle, Female, 10 Years	Grandparent, Female, 37 Years	Inadequate Guardianship	Substantiated
Aunt/Uncle, Male, 8 Years	Grandparent, Female, 37 Years	Educational Neglect	Substantiated
Aunt/Uncle, Male, 8 Years	Grandparent, Female, 37 Years	Inadequate Guardianship	Substantiated
Aunt/Uncle, Male, 7 Years	Grandparent, Female, 37 Years	Educational Neglect	Substantiated
Aunt/Uncle, Male, 7 Years	Grandparent, Female, 37 Years	Inadequate Guardianship	Substantiated
Mother, Female, 13 Years	Grandparent, Female, 37 Years	Lack of Medical Care	Substantiated
Aunt/Uncle, Female, 10 Years	Grandparent, Female, 37 Years	Lack of Medical Care	Substantiated
Aunt/Uncle, Male, 7 Years	Grandparent, Female, 37 Years	Lack of Medical Care	Substantiated

Report Summary:
This report was received with concerns the then 8yo was failing the 2nd grade due to excessive absences and tardiness. The report alleged the CH had 19 referrals for discipline due to his behavioral issues in school. The school requested MGM have the CH complete a MH evaluation but MGM did not comply. The report further alleged the CH had assaulted staff and students. There were further concerns the other CHN were also missing school and failing as a result, and MGM was not addressing the concerns.

Report Determination: Indicated | **Date of Determination:** 06/12/2017

Basis for Determination:
RCDSS gathered information from the CHN's schools to support the allegations. MGM was uncooperative throughout the investigation; however, RCDSS made diligent efforts to try to engage her and the family. RCDSS consulted with their legal department and it was decided a Neglect Petition would be filed. The case was indicated and opened for services on 6/5/17.

OCFS Review Results:
Although information was gathered in subsequent reports regarding the biological fathers of the children, this information was not carried over into this case. Otherwise, this investigation met all statutory requirements.

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)
02/08/2017	Aunt/Uncle, Male, 8 Years	Grandparent, Female, 36 Years	Lack of Medical Care	Unsubstantiated	Yes
	Aunt/Uncle, Female, 10 Years	Grandparent, Female, 36 Years	Educational Neglect	Substantiated	
	Aunt/Uncle, Male, 8 Years	Grandparent, Female, 36 Years	Educational Neglect	Substantiated	
	Aunt/Uncle, Male, 6 Years	Grandparent, Female, 36 Years	Educational Neglect	Substantiated	

Report Summary:
This report was received with concerns that MGMs children missed numerous days of school and, as a result, were falling behind. The report alleged the then 8yo child was having behavioral issues and was suspended; MGM was aware and not following through with recommendations for mental health treatment.

Report Determination: Indicated **Date of Determination:** 04/27/2017

Basis for Determination:
RCDSS interviewed MGM regarding the allegations and completed home visits. RCDSS spoke with all the CHN together at their home and they expressed no safety concerns. RCDSS spoke with the CHNs schools and found the CHN were regularly absent or tardy and the 8yo CH had behavioral concerns. RCDSS offered a referral for services for the family. The allegation of EdN was substantiated and the case was closed.

OCFS Review Results:
The 7 Day Safety Assessment was late and many progress notes were not entered contemporaneous. The RAP was inaccurate. Case notes were not carried over from subsequent investigations into this investigation.

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 6 days late.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Within seven days of receiving a report, RCDSS 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.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Many notes were entered more than one month after event dates.
Legal Reference:
18 NYCRR 428.5
Action:
RCDSS will enter progress notes contemporaneously as events occur.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:

The following RAP questions should have been answered "Yes": #4 (unstable housing), #5 (mismanaged financial resources); The following should have been answered "No": #14 (attends to needs of all CHN), #15 (understands seriousness and willing to address concerns). MGM was evicted from her apartment and was not following through on the school's recommendations regarding the CHN's attendance and MH.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

Issue:

Face-to-Face Interview (Subject/Family)

Summary:

RCDSS did not make diligent efforts to locate and speak with the biological fathers of the children.

Legal Reference:

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

Action:

RCDSS will make efforts to interview all persons named in a report, face to face, who may have been present during what was alleged in the report, and/or may have information pertinent to the safety and well-being of children that reside in the home, including absent biological parents.

Issue:

Failure to provide notice of report

Summary:

Notice of Existence Letters were not mailed/delivered to the biological fathers until 4/25/17.

Legal Reference:

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

Action:

RCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/22/2016	Other - UA1, Male, 8 Years	Other - MGM, Female, 36 Years	Lack of Medical Care	Unsubstantiated	No
	Other - UA1, Male, 8 Years	Other - PGF, Male, 48 Years	Lack of Medical Care	Unsubstantiated	
	Other - UA4, Male, 15 Years	Other - MGM, Female, 36 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Other - UA4, Male, 15 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Other - UA4, Male, 15 Years	Other - MGM, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other - UA4, Male, 15 Years	Other - PGF, Male, 48 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Other - UA4, Male, 15 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated	

Other - UA4, Male, 15 Years	Other - PGF, Male, 48 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Mother, Female, 12 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated
Mother, Female, 12 Years	Other - MGM, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Aunt/Uncle, Female, 10 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated
Aunt/Uncle, Female, 10 Years	Other - MGM, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other - UA1, Male, 8 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated
Other - UA1, Male, 8 Years	Other - MGM, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other - UA2, Male, 6 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated
Other - UA2, Male, 6 Years	Other - MGM, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Mother, Female, 12 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated
Mother, Female, 12 Years	Other - PGF, Male, 48 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Aunt/Uncle, Female, 10 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated
Aunt/Uncle, Female, 10 Years	Other - PGF, Male, 48 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other - UA1, Male, 8 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated
Other - UA1, Male, 8 Years	Other - PGF, Male, 48 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other - UA2, Male, 6 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated
Other - UA2, Male, 6 Years	Other - PGF, Male, 48 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
This report was received with concerns MGM and her husband (BF1) smoked marijuana to the point of impairment while caring for the CHN. The report alleged a recent incident occurred where BF1 drove with the CHN in the car while impaired. There were further concerns the eldest CH (UA4) was also smoking marijuana. The parents failed to follow through with referrals for a MH evaluation for one of the CH.

Report Determination: Unfounded | **Date of Determination:** 02/07/2017

Basis for Determination:
RCDSS completed interviews with all individuals; no safety concerns were expressed by the CHN. The CH in need of MH treatment was engaged in services. Collateral sources were contacted and no concerns were noted. MGM was working with the school to address CHN's behavioral concerns. The investigation was unfounded and closed, referred to community-based services only.

OCFS Review Results:
This investigation met all statutory requirements.

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)
01/13/2016	Other Adult - 1, Male, 18 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other - UA4, Male, 15 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Mother, Female, 12 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Other Adult - 1, Male, 18 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Other - UA4, Male, 15 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Mother, Female, 12 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Aunt/Uncle, Female, 9 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Other - UA1, Male, 7 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Other - UA2, Male, 5 Years	Other - MGM, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Aunt/Uncle, Female, 9 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Other - UA1, Male, 7 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Other - UA2, Male, 5 Years	Other - PGF, Male, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Mother, Female, 12 Years	Other - MGM, Female, 36 Years	Educational Neglect	Unsubstantiated	
	Aunt/Uncle, Female, 9 Years	Other - MGM, Female, 36 Years	Educational Neglect	Unsubstantiated	
	Other - UA1, Male, 7 Years	Other - MGM, Female, 36 Years	Educational Neglect	Unsubstantiated	
	Mother, Female, 12 Years	Other - PGF, Male, 48 Years	Educational Neglect	Unsubstantiated	
	Aunt/Uncle, Female, 9 Years	Other - PGF, Male, 48 Years	Educational Neglect	Unsubstantiated	
	Other - UA1, Male, 7 Years	Other - PGF, Male, 48 Years	Educational Neglect	Unsubstantiated	
	Mother, Female, 12 Years	Other - MGM, Female, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

Aunt/Uncle, Female, 9 Years	Other - MGM, Female, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other - UA4, Male, 15 Years	Other - MGM, Female, 36 Years	Childs Drug / Alcohol Use	Unsubstantiated
Other - UA4, Male, 15 Years	Other - MGM, Female, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated

Report Summary:
This report was received by Dutchess County Department of Social Services (DCDSS) with concerns the CHN were excessively absent and tardy, and it was negatively impacting their grades. There were further concerns of the CHN's hygiene. The report alleged the MGM failed to pick up the then 5yo CH at the bus stop on at least 2 occasions. The school attempted to reach out to MGM regarding the concerns; however, MGM would not address them.

Report Determination: Unfounded | **Date of Determination:** 03/26/2016

Basis for Determination:
DCDSS spoke with the family and school regarding the report. The CHN did not express any safety concerns. DCDSS provided MGM with a referral for services. By the close of the investigation, the school reported there were no further complaints regarding the CHN. The investigation was unfounded and closed.

OCFS Review Results:
Although the concerns in the report were explored with the family in the initial investigation, the notes were not carried over into this subsequent report's case record.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
Although the concerns in the report were addressed in the initial investigation received, the information reflecting such were not pulled forward into this subsequent case.

Legal Reference:
18 NYCRR 428.5

Action:
DCDSS will enter progress notes contemporaneously as events occur, including carrying over information which reflects duplicate casework completed in concurrent investigations.

[redacted]

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

3/10/10- UNF allegations of EdN, IG and LM against MGM and MGF regarding CHN.
5/18/10: UNF allegations of IG against MGM and MGF regarding CHN.
6/13/11: IND allegations of IG against MGM and MGF regarding CHN.
10/25/11: UNF allegations of IF/C/S and IG against MGM regarding CHN.
3/14/12: IND allegations of L/B/W and IG against MGM regarding one MU.
11/19/15: UNF allegations of IG against MGM regarding eldest MU.
1/13/16: UNF allegations of IG, IF/C/S, and EdN against MGM and BF regarding CHN.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Preventive Services History

A CPS services case was opened in Renssealear County in June 2017 due to ongoing concerns regarding the family, which included unstable housing, the CHN not attending school regularly, and MGM's failure to follow through with recommendations regarding PINS and MH evaluations for the CHN. In January 2018, there was a finding of neglect in Family Court. The services case was transferred between Albany and Rensselaer Counties more than once due to the family moving often. At the time of the neglect finding, the family resided in Albany County. A one-year order of supervision was implemented. Toward the end of the case, the CHN were attending school regularly and had secured an apartment; however, the family moved to Poughkeepsie during the open case, and were unable to be contacted or located. The family did return to Rensselaer County, but again, they were unable to be contacted or located. The case was closed in February 2019.

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

Rensselaer County Department of Social Services Comments:

It was Rensselaer County's interpretation of the guidance provided by OCFS in February of 2018 that reasonable efforts must be made for face-to-face contact with a non-custodial parents only if a child has contact with said non-custodial parent in their home. Given the father in this case was incarcerated and did not have any contact with the children, RCDSS did not feel it necessary to interview him face to face as he could not provide valuable information that could speak to the children's safety. He was provided written notification of the report.

Dutchess County Department of Social Services Comments:

Dutchess County did address the allegations in both the Initial and Subsequent investigations. A summary of the information learned was contained in the Investigation Conclusion. The Progress Notes were not able to be transferred over entirely as some pre dated the Subsequent Investigation. All issues of Safety and Risk were adequately addressed.

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