Child Fatality Report

Report Identification Number: RO-18-024

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

Issue Date: Feb 08, 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		

Case Information

Report Type: Child Deceased
Age: 28 day(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 11/07/2011
Initial Date OCFS Notified: 08/28/2018

Presenting Information

An SCR report was received on 8/28/18 that alleged some time in November 2011, the subject child was born prematurely, and the mother and father co-slept with the child often. The report further alleged on a date in January 2012, the mother put the child to bed in her crib and went to bed. The father then came home intoxicated, picked the child up, put her on his chest and fell asleep in the bed next to the mother. The report stated the mother then woke up to feed the child, and found the father sleeping and the child's arm sticking out from beneath him. The child was unresponsive with blood and discharge coming from her nose. The other children that resided in the household had unknown roles.

Executive Summary

This fatality report concerns the death of a 1-month-old subject child (SC). Although the SCR report alleged the child died some time in January 2012, the death actually occurred on 11/7/11. A report was made to the SCR on 8/28/18, with allegations of Inadequate Guardianship, Parent's Drug/Alcohol Misuse, and DOA/Fatality against the subject child's father (SF). Monroe County Department of Human Services (MCDHS) received the report and investigated the subject child's death. An autopsy was completed on 11/7/11. The manner of death was ruled "Accidental," and the cause was noted as "Positional Asphyxiation."

At the time of the subject child's death, she resided with her mother (BM), father, and five surviving siblings (SS, ages 4, 8, 11, 12, and 14). It was discovered on the night of 11/6/11, the mother and subject child went to bed at approximately 10:30PM. The father stayed up to watch television, and drank approximately 5 beers. At around 12:30AM on 11/7/18, the father fed and changed the subject child, then got into bed with the mother; the father laid the child on her stomach, on his chest. At roughly 4:30AM, the mother awoke the father asking where the subject child was. The father was laying on his stomach and found the subject child underneath him, unresponsive. The parents contacted Emergency Medical Services and the subject child was transported to the hospital via ambulance where she was pronounced deceased.

The mother was not cooperative with Child Protective Services during the fatality investigation, and the father could not be located. It was not documented in this investigation whether or not the parents were educated surrounding safe sleep practices, nor if they had appropriate provisions for the SC at the time of her death. MCDHS gathered most of the information related to the subject child's death from collateral sources, including police reports and the final autopsy.

Although the two oldest siblings (now adults) were at home during MCHDS' initial contact with the family, there were no documented attempts to interview them regarding the fatality. At the time of this investigation, the mother's 2-month-old granddaughter lived in the home. The 2-month-old's mother also resided with the family. There was nothing documented that MCHDS educated any caregivers surrounding safe sleep practices. MCDHS also did not add the 2-month-old or her mother to the case composition. There were no criminal charges pursued regarding the subject child's death. Sufficient evidence was gathered to substantiate the DOA/Fatality allegation; however, MCDHS chose to unsubstantiate due to the manner of death being "Accidental."

PIP Requirement
MCDHS will submit a Program Improvement Plan (PIP) to their Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) MCDHS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, MCDHS will review the plan(s) and revise as needed to further address on-going concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:
MCDHS gathered evidence to substantiate all allegations; however, chose to unsubstantiate the DOA/Fatality allegation.

Was the decision to close the case appropriate? Yes

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 level of casework activity was commensurate with the case circumstances. The decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The ME noted SC's cause of death as "Positional Asphyxiation" and noted history of co-sleeping. A causal link was found between SC's death and the actions of SF drinking and co-sleeping with SC; however, MCDHS Unsub the DOA/Fatality allegation.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	MCDHS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).
Issue:	Contact/Information From Reporting/Collateral Source

Summary:	MCDHS did not document attempts to contact all appropriate collateral sources, including first responders and the hospital where SC was taken via ambulance on the date of the incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	MCDHS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.
Issue:	Face-to-Face Interview (Subject/Family)
Summary:	Although the now-adult siblings were present during MCDHS' initial contact with the family, there were no further attempts to interview them regarding SC's death. Both siblings were living in the household at the time SC died.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.
Issue:	Failure to provide safe sleep education/information
Summary:	At the time of the fatality investigation, a 2-month-old was residing in the household. Documentation did not reflect that MCDHS educated the parents/caregivers surrounding safe sleep practices.
Legal Reference:	13-OCFS-ADM-02
Action:	MCDHS will provide information on sleep safety to the parents and caretakers of infants whom they encounter, and see that necessary steps are taken to provide safe sleeping conditions for the children in their care.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/07/2011 **Time of Death:** 04:30 AM (Approximate)

Date of fatal incident, if different than date of death: 01/01/2012
Time of fatal incident, if different than time of death: Unknown

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? 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? 4 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	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	14 Year(s)
Other Household 1	Other Adult - BF to SS1	No Role	Male	31 Year(s)
Other Household 2	Other Adult - BF to SS2	No Role	Male	27 Year(s)

LDSS Response

On 8/28/18, MCDHS received the SCR report regarding the death of SC, which occurred on 11/7/11. MCDHS initiated their investigation of the reported fatality within 24 hours and coordinated their efforts with their Multidisciplinary Team. MCDHS contacted LE, and were informed SC's death was already investigated in 2011. LE reported no criminality was found and they would not be re-opening their case.

On the date the report was received, MCDHS completed a home visit to BM's address. Although BM was not fully cooperative, MCDHS was able to speak with her briefly and observe all the CHN named on the report; no safety concerns were noted. The fatality allegations were not addressed on this date. On 8/29/18, MCDHS completed another home visit to discuss the fatality with BM; however, BM would not allow the caseworkers into her home or allow them to observe the CHN. BM did inform MCDHS that SC's death was already investigated by LE, and SF had since moved to Georgia. BM reported she nor her CHN have had any contact with SF in 3 years, and SM denied having any contact information. MCDHS made efforts to locate SF, but were unsuccessful. BM stated she was aware on the date of SC's death SF had one alcoholic beverage, but was not aware he had more than that. BM refused to speak to the caseworker further, and although preventive services were offered at that time, BM declined.

MCDHS obtained a copy of the police report and SF's statement to LE from the date of SC's death. Information surrounding the incident was noted. SF had informed LE on the night of 11/6/11 he was watching a football game, and throughout the night he consumed 4 or 5 beers; BM and SC had gone upstairs to sleep around 10:30PM. SF explained at about 12:30AM, BM called for him to come to bed. SF reported to LE he gave SC a bottle, changed her, and then brought her back into the adult bed with him and BM. SF stated he placed SC stomach down on his chest. SF informed LE that BM awoke him around 4AM and asked where SC was. SF stated he was laying on his stomach and found SC underneath him,

unresponsive. EMS was called and SC was transported to the hospital where she was pronounced deceased.

MCDHS spoke with the ME regarding SC and was informed the manner of death was found to be "Accidental," and the cause, "Positional Asphyxiation." The autopsy also noted a history of co-sleeping and no acute fractures or other evidence of trauma.

On 9/7/18, MCDHS met with the then 4 and 8 year old SS at their schools. Both SS had knowledge that SF rolled over on SC while he was asleep, and that was how SC died. Neither disclosed any safety concerns and both denied having any recent contact with SF. MCDHS attempted to meet with the then 11 year old SS at the school; however, she stated she did not want to speak with CPS. This SS did report she had no concerns at home prior to exiting the interview.

Throughout the investigation, MCDHS spoke with collateral sources including LE, the ME, the CHN's schools and pediatrician. MCDHS also interviewed two of the biological fathers of the SS over the phone; no concerns were noted by either. MCDHS found evidence to substantiate the allegations of IG and PD/AM; however, unsubstantiated the DOA/Fatality allegation noting SF did not intentionally roll over onto SC. The official autopsy results provided the causal link needed in order for MCDHS to substantiate the allegation as it related to unsafe sleep and SC's death. The case was indicated and closed.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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 Monroe County Multidisciplinary Team.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048941 - Deceased Child, Female, 2 Mons	048945 - Father, Male, 26 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
048941 - Deceased Child, Female, 2 Mons	048945 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
048941 - Deceased Child, Female, 2 Mons	048945 - Father, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐

When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:
MCDHS spoke with LE, who stated they investigated SC's death in 2011 and found no criminality. MCDHS did not document any attempts to locate or speak with SF. MCDHS did not interview the two now-adult siblings who were CHN at the time of SC's death.

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: The Risk Assessment was completed accurately. Preventive services were offered to the family but declined.				

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?	☐	☒	☐	☐
Explain as necessary: No children needed to be removed as a result of this fatality investigation or for reasons unrelated.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

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

Additional information, if necessary:
MCDHS offered the family services, including preventive services, but the family declined. Due to SM's history of housing struggles and ongoing financial hardships to meet all of her children's needs, a referral for family planning services would have been appropriate.

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:
Although MCDHS offered services to all family members regarding the fatality, they were declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
MCDHS offered SM preventive services, but she declined.

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? No
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
☐ Had heavy alcohol use
☐ Smoked tobacco

☐ Experienced domestic violence
☒ Used illicit drugs
☐ Was not noted in the case record to have any of the issues listed

Infant was born:
☐ Drug exposed
☐ With fetal alcohol effects or syndrome
☒ With neither of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/13/2011	Deceased Child, Female, 3 Days	Mother, Male, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:
This report was received with concerns SM tested positive for marijuana at the time of delivery of SC; SC tested negative.

Report Determination: Unfounded
Date of Determination: 10/28/2011

Basis for Determination:
MCDHS completed a thorough investigation of the concerns alleged in the report. SM reported she used marijuana once during her pregnancy and had not used since SC was born. SM denied using when caring for her CHN. All CHN were seen and assessed, as was the home environment; no safety concerns were noted. SM had appropriate provisions for SC. MCDHS educated SM surrounding safe sleep practices; however, SM was adamant she would co-sleep with SC, as she co-slept with all of her CHN. Services were offered but declined. MCDHS unfounded their investigation and closed.

OCFS Review Results:
MCDHS did not add or notify the SS' biological fathers of the CPS investigation. The decision to unsubstantiate the allegations and close was appropriate.

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

Issue:
Failure to provide notice of report
Summary:
The biological fathers of the SS were not added to the report or notified of the CPS investigation involving their children.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
MCDHS 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)
11/30/2008	Sibling, Male, 1 Years	Mother's Partner, Male, 23 Years	Burns / Scalding	Unsubstantiated	Yes
	Sibling, Male, 1 Years	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	

	Sibling, Male, 1 Years	Mother's Partner, Male, 23 Years	Lack of Supervision	Unsubstantiated

Report Summary:
This report was received with concerns the PS was not properly supervising the then 1yo SS, and as a result the child sustained 2nd degree burns from falling onto a hot iron. The report further alleged the child sustained a burn from the same iron three weeks prior. SM and the other SS had unknown roles.

Report Determination: Unfounded | **Date of Determination:** 01/22/2009

Basis for Determination:
MCDHS interviewed SM, PS, and all verbal SS. The home was observed and no safety concerns were noted. It was determined SM had been ironing and left the iron to cool down on the floor of the living room. SM reported she told PS to watch the CHN and informed him the iron was still hot while she went to shower. PS stated he went to answer the phone and that is when the 1yo SS was burned. SM and PS acted appropriately and sought immediate medical attention. Collateral sources were spoken with. SM followed through with all appointments and treatment recommendations for the 1yo SS. MCDHS offered the family preventive services, which were declined. MCHDS unfounded the investigation and closed.

OCFS Review Results:
The decision to unsubstantiate the allegations was appropriate. The RAP was inaccurate regarding the housing and financial resources question. There were no attempts to speak with the SS' biological fathers, even though some of the CHN had regular contact with them.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
Several times throughout the investigation, SM mentioned not having finances to meet the basic needs of the CHN (money for the bus for doctor visits and for CHN to get to school, money to wash clothes, running short on food). There was also a note which stated SM had a long history of evictions. The questions pertaining to these issues on the RAP should have been marked "yes", but were marked "no.
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.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
Several of the SS stated to the CW they saw their biological fathers regularly, but MCDHS did not reach out to any of the fathers as collateral sources of information surrounding the safety of the CHN. Further, MCDHS did not follow up with all of the teachers who expressed serious concerns re: the CHN's grades, major behavioral issues, and lack of communication/cooperation from SM.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
MCDHS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Failure to provide notice of report
Summary:

The biological father's of the SS were not added to the report or notified of the CPS investigation involving their children.

Legal Reference:

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

Action:

MCDHS 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.

[redacted]

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

11/2008: UNF against unrelated adult for B/S, IG, and LS regarding the then 4yo SS.
12/2004: IND against SM for IF/C/S and IG regarding the two oldest SS, as well as the then 11 and 8 yo SS.

Known CPS History Outside of NYS

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

Preventive Services History

On 8/31/06, a preventive services case was opened due to SM failing to follow through with the MH and medical needs of her CHN, as well as a recent eviction and financial struggles. SM was not cooperative with services, but was able to secure daycare for her younger CHN and stable housing. SM reported she received help from the CHN's BFs. The case was closed on 11/3/06, and it was noted services were no longer needed.

On 4/30/05, a preventive services case was opened after the now adult sibling was referred via his school. SM expressed she did not want to engage in services and was uncooperative with the preventive worker. The case was closed on 6/23/05, and it was noted services were no longer accepted. The documentation did not reflect if MCDHS considered legal intervention to compel services.

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