Child Fatality Report

Report Identification Number: SV-18-027

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

Issue Date: Sep 18, 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: 26 day(s)
Jurisdiction: Dutchess
Gender: Female
Date of Death: 04/28/2018
Initial Date OCFS Notified: 05/01/2018

Presenting Information

OCFS received notification of the SC's death on 4/29/18. The SC was 26 days old at the time of her death, and had never left the hospital since the time she was born. The SC was born premature at 25 weeks' gestation with medical complications associated with prematurity. On 4/28/18, the SC was having difficulty breathing and exhibited shallow breaths. She was intubated as a result. Hospital staff made resuscitative efforts when SC exhibited no heart beat, and after 15 minutes, the SC was declared deceased.

Executive Summary

This fatality report concerns the death of the SC, who was born and died while her family was receiving Preventive Services and CPS monitoring with the Dutchess County Department of Community and Family Services (DCDCFS). The SC was 26 days old at her time of death, and had never left the hospital due to being born extremely premature. DCDCFS learned of the fatality on 4/29/18 and immediately notified the Spring Valley Regional Office with the required 7065-Agency Reporting Form.

The SC's mother, BM, was 16 years old and was a child receiving Preventive Services along with her 3 siblings and her mother (MGM). The SC's BF was identified as the BM's 16-year-old boyfriend, who resided elsewhere. A concern that was addressed during the open Preventive case had been MGM's allowance of the BM and BF's sexual relationship; an order of protection had been in place prohibiting their contact, beginning 10/19/2017.

The SC was born on 4/2/18 at approximately 25 weeks' gestation with no pre-existing concerns. Hospital staff noted the SC was to be hospitalized in the Neonatal Intensive Care Unit (NICU) for approximately 10 weeks or more. Staff reported the SC's prognosis was good at the time of her birth, but could change at any moment. Medical documentation showed the SC exhibited respiratory complications and an infection while she was in the NICU, for which treatments were administered. The BM visited the SC daily, from the time of her birth to the time of her death. The BF saw the SC when she was born, and signed papers at the hospital to acknowledge paternity.

According to the family and medical documentation received, on 4/28/18, the SC's condition declined in the form of respiratory failure. She began having periods of apnea which progressed to bradycardia (low heart rate). Medical interventions ensued during this period, until SC exhibited no heart rate. After 28 minutes of no heart rate, resuscitative efforts ceased. No autopsy was completed. Based on the information DCDCFS gathered, there was no reason to suspect the cause of death was a result of abuse or maltreatment.

DCDCFS assisted with burial expenses and encouraged grief counseling for the family. It was documented BM addressed her grief within the MH services she was already receiving. DCDCFS provided staff at BF's non-secure detention facility, where he resided, with information on a resource to provide grief counseling. Though they tried to do so immediately upon learning of the fatality, DCDCFS met with the family in their home on 5/14/18; no concerns were noted.

DCDCFS addressed a new SCR report which was made against the MGM in June of 2018 with concerns unrelated to the fatality; that investigation closed 8/1/18. DCDCFS and the Preventive agency continued working with the family at the time this fatality report was written.

During OCFS' review of history, a concern was found regarding DCDCFS' practice in 2 prior Preventive Services cases

as it pertained to the provision of services for BM's father (MGF). In those cases, it was noted MGF was either in need of or being provided services to offset identified risks. It was apparent he was not added to either case. It is important to include all parents in service plans and the provision of services, especially in instances where needs are identified. The failure to include this father in the provision of court-ordered and necessary services was an example of non-compliance with state regulations, and occurred on two different occasions. This matter has been referred to the Spring Valley Regional Office for consideration.

PIP Requirement

For issues identified in historical cases, DCDCFS will submit a PIP to the Spring Valley Regional Office within 30 days of receipt of this report. The PIP will identify action(s) DCDCFS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, DCDCFS 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

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:

There was no determination safety assessment or determination of allegations as there was no SCR report alleging the fatality was suspected to be a result of abuse or maltreatment. The CPS Services/Preventive case record contained detailed notes of casework activity, commensurate with case circumstances, as well as documentation of consultation with supervisors.

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: 04/28/2018 **Time of Death:** 05:23 PM

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

County where fatality incident occurred: Dutchess
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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: 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	Aunt/Uncle	No Role	Male	8 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	15 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	12 Year(s)
Deceased Child's Household	Deceased Child	No Role	Female	26 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	33 Year(s)
Deceased Child's Household	Mother	No Role	Female	16 Year(s)

LDSS Response

DCDCFS had substantial history with the SC's maternal family prior to the fatality. The most recent involvement began on 10/18/17 when an SCR report was made against MGM; a CPS Services case was opened the next day, and later the case was transitioned to include Preventive Services. This case was open at the time of the fatality and remained open at the time of this writing. DCDCFS worked to address ongoing concerns with MGM as a parent to BM and BM's 3 siblings, (maternal uncles – MU) ages 15, 12, and 8.

Upon SC's birth, hospital staff referred BM to a teen parenting program and public health nurse, to which BM was receptive. DCDCFS discussed post-partum depression with BM and provided her the number for Mobile Crisis due to her MH history. MGM noted she planned to call BM's MH provider to schedule an appointment upon discharge.

The MGM and BM reported to DCDCFS that they discovered BM was pregnant in December of 2017 and shortly

afterwards BM began receiving prenatal healthcare. The family stated BM's 16-year-old boyfriend was the father, and they chose not to report the pregnancy to their CPS CW who was involved at the time.

MGM told the Preventive worker she allowed BM and BF to be together to meet the baby, sign papers to establish paternity, and see each other at the time of SC's death. The DCDCFS CW and attorney addressed concerns, with MGM and her attorney, that the OP was not followed on those occasions, as well as other aspects of the court order not being followed (such as signing releases and providing MGM's work schedule). After the SC's death, a compromise was made for the BM and BF to have phone contact daily for 15 minutes and attend therapy together. A Family Court hearing on 5/23/18 noted the agreed-upon amended order regarding phone contact for therapeutic purposes.

BM visited the SC daily and staff reported no concerns. BM utilized her MH services with no concerns for compliance noted from the provider. DCDCFS obtained all medical records regarding the SC from the time of her birth to the time of her death, including information surrounding the circumstances of the death, which in nature were not suspicious of abuse or maltreatment.

Following the fatality, despite efforts to do so sooner, DCDCFS met with the family in their home on 5/14/18, at which time all CHN were seen. On 5/17/18, a new Preventive worker engaged with the family in the home to discuss a transition into Preventive Services. An outside agency became involved in the Preventive case in June of 2018, and the Family Specialist maintained an active role with the family and monitored all services. Another CPS report was made on 6/18/18 with concerns unrelated to the fatality. The Preventive Family Specialist addressed this and other areas of concern with the family (such as cleanliness of the home), as well as the CPS CW assigned to investigate. The agencies remained involved with the family.

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: Unknown

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Review Team in Dutchess County.

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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

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

Explain:
The above-mentioned safety assessments were not required as the fatality was not reported to the SCR. DCDCFS attempted to meet with the family upon first learning of the fatality, though the family declined. DCDCFS made successful face-to-face contact with the BM, MGM, and BM's siblings on 5/14/2018.

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:
No new petition was filed, but there was ongoing court activity related to the protective concerns, following the fatality. Services continued to be provided.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? 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:
Preventive Services involved: MGM agreed to participate in a parenting class to address new issues that arose during the life of the case. BM remained active in MH services; MGM was court-ordered for a MH evaluation and to participate in family therapy but that had yet to occur. BM submitted to random drug testing. It may have been beneficial to offer family planning services to 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:
It was not apparent from the case record that there were any needs related to the fatality for the BM's siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
It was documented BM addressed her grief surrounding the fatality in her MH sessions as well as when needed with her school counselor. Grief services, as well as family therapy, were referred for the MGM and their family though it was not apparent any services were utilized (other than for the BM) prior to the writing of this report.

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?	N/A
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)
10/18/2017	Mother, Female, 16 Years	Grandparent, Female, 32 Years	Inadequate Guardianship	Substantiated	Yes
	Father, Male, 16 Years	Grandparent, Female, 32 Years	Inadequate Guardianship	Substantiated	
	Mother, Female, 16 Years	Grandparent, Female, 32 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Mother, Female, 16 Years	Grandparent, Female, 32 Years	Sexual Abuse	Unsubstantiated	
	Father, Male, 16 Years	Grandparent, Female, 32 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Father, Male, 16 Years	Grandparent, Female, 32 Years	Sexual Abuse	Unsubstantiated	

Report Summary:
An SCR report alleged MGM was allowing BM and a male child (BF), both age 16, to engage in a sexual relationship as well as use drugs in her home. MGM was aware that the 2 children were smoking marijuana daily and having sex, and failed to intervene. The BF's father had an unknown role.

Report Determination: Indicated **Date of Determination:** 01/09/2018

Basis for Determination:
MGM was IND for IG regarding the CHN as she admitted to allowing them to engage in an ongoing sexual relationship in her home for over a year. MGM supplied them with birth control and knew at one time BM thought she was pregnant, yet MGM continued to allow the behavior and let the boy move into her home, staying in BM's bedroom. SA was Unsub as the information learned did not support the criteria for a finding for that allegation. The 2 CHN admitted to marijuana use but denied MGM had any knowledge; for that reason, CD/A was Unsub. A Neglect Petition was filed and a Preventive Services case was opened. DCDCFS noted MGM did not recognize the CPS concerns.

OCFS Review Results:
DCDCFS appropriately IND the case, opened a Preventive Services case, and intervened when necessary (ie. calling Mobile Crisis and filing a petition to enforce that MGM not allow contact between the CHN - an OP was issued). DCDCFS worked with both BM's and BF's families. During the investigation, BF went into a non-secure detention facility due his ongoing behavior issues. DCDCFS did not make efforts to interview or notify 2 BFs or add the youngest MU's BF whom the CHN identified as residing in the home.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
DCDCFS did not make efforts to notify or interview 2 BFs or add MU3's BF, whom the CHN identified as residing in the home.

Legal Reference:
432.1 (o)

Action:
DCDCFS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:

Failure to provide notice of report

Summary:

There was no documentation that either father was sent a Notice of Existence letter regarding the report.

Legal Reference:

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

Action:

DCDCFS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/04/2017	Mother, Female, 15 Years	Grandparent, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Mother, Female, 15 Years	Grandparent, Female, 32 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:

An SCR report alleged a history of MGM being physically and verbally abusive to BM (age 15). MGM had beaten BM with a belt and spoke to her in derogatory terms, and this occurred on a regular basis. On the report date, BM was undergoing a psychological evaluation for self-harming behaviors when MGM screamed at and berated BM, and refused to allow her to answer questions. The hospital called the police and due to MGM's behavior, staff were unable to adequately ascertain BM's immediate medical needs in a timely manner. BM was to be admitted to the hospital but because MGM left, the process could not be completed. Two other CHN in the home had unknown roles.

Report Determination: Unfounded | **Date of Determination:** 07/10/2017

Basis for Determination:

DCDCFS concluded there was no credible evidence MGM maltreated BM. They learned MGM addressed BM's self-harming behaviors by taking off her bedroom door and telling her she needed counseling, but this occurred prior to the investigation. Regarding the alleged incident, MGM was allowed to leave to care for her other CHN; MGGM came in her place. BM became engaged in MH Tx. The 4 CHN reported feeling safe, but they all admitted to getting hit with a belt by MGM in the past for discipline. Despite this, it was not asked whether they sustained marks/injuries as a result, so it is unclear whether an appropriate determination was made about this. MGM accepted referrals to community-based services.

OCFS Review Results:

DCDCFS addressed the allegations and followed up after BM was discharged from in-patient MH Tx, and learned BM was doing better and had not had self-harming behaviors or thoughts since leaving the hospital and continuing therapy. DCDCFS spoke with relevant collateral contacts, but did not interview 2 BFs named on the case. MU3's BF's information and demographics were never updated in CONNECTIONS; therefore, pertinent information surrounding his history was inaccurately recorded in the case record. For example, the RAP did not capture his history of a prior TPR, greatly affecting the overall score. Credible evidence was found and documented to IND the report, though it was UNF.

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

Issue:

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:

BM's father, as well as the father of one of the MUs, were named in the report and notified about the investigation. It was identified that both fathers had involvement with the children, though there was no documented effort to interview either of them.

Legal Reference:
432.1 (o)
Action:
DCDCFS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Case record contains information that is relevant, useful, factual and objective
Summary:
MU3's BF's information and demographics were never updated in CONNECTIONS; therefore, pertinent information such as his actual name, birthdate, and CPS history was inaccurately recorded in the case record of this investigation.
Legal Reference:
18 NYCRR 428.1 (b)(1)
Action:
DCDCFS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP did not capture that MU3's BF, the secondary caretaker listed, had his parental rights terminated to one of his CHN. This would have greatly affected the overall RAP score.
Legal Reference:
18 NYCRR 432.2(d)
Action:
DCDCFS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Determination of Nature, Extent and Cause of Conditions (Report)
Summary:
The report included allegations that MGM hit BM with a belt for discipline; all 4 CHN confirmed MGM used a belt to discipline them in the past, yet MGM denied. Despite these disclosures, the CW did not ask of any of them whether they sustained injuries or marks as a result. Pertinent information was not gathered to determine if the discipline used was inappropriate.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(d)
Action:
DCDCFS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute abuse or maltreatment.

Issue:
Appropriateness of allegation determination
Summary:
The record reflected MGM was aware of BM's self-harming behaviors within the 2 years prior to the report and did not seek medical or MH Tx until after BM was hospitalized at the onset of the investigation. Despite the credible evidence found to support an IND determination, the report was UNF.
Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

DCDCFS will refer to the CPS Program Manual and/or consult with the Spring Valley Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

[redacted]

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

8/2/02-10/1/02 MGGM was IND for PD/AM, and a PS was IND for IG regarding BM.

6/12/06-11/28/06 MGM & MGF were IND for LS & PD/AM regarding BM, MU1 & MU2.

9/8/06-11/28/06 MGM & MGF were IND for IG & PD/AM regarding MU1 & MU2. Neglect petition filed against MGM to compel services; services case opened.

5/22/07-8/26/07 MGM was IND for IG, LS, & PD/AM regarding MU1 & MU2; the same allegations against maternal great uncle were Unsub.

8/30/07-11/3/07 MGM & a PS were IND for IG regarding BM, MU1 & MU2. A violation petition was filed in Family Court due to DV concerns, and a full stay-away OP was issued against the PS to protect MGM & the CHN.

8/24/08-10/2/08 MGM was UNF for II, LS & IG regarding MU2.

6/1/09-6/19/09 MGM & MU3's BF were IND, MGM for PD/AM and MU3's BF for IG regarding MU3; services case opened.

7/28/09-8/11/09 MGM & MU3's BF were IND for IG regarding MU2 & MU3, as well as PD/AM against MU3's BF. CHN removed per court order 7/31/09.

7/31/09-8/11/09 MGM & MU3's BF were IND for PD/AM & IG regarding BM, MU1, MU2 & MU3; MGF was IND for IG regarding MU2 (though it was noted he was meant to be IND regarding all CHN).

8/17/09-11/5/09 MGM, MGF, and a maternal great aunt (MGA) were UNF for SA regarding MU1 & MU2 while they were in FC.

10/8/09-2/3/10 MGGF & MGA were UNF for IG and OTH (sex offender in home) regarding MU1 & MU2.

2/18/15-4/2/15 MGM & an "unknown BF" were UNF for IG & PD/AM regarding BM, MU1, MU2 & MU3, as well as LMC regarding MU2.

Known CPS History Outside of NYS

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

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 10/19/2017

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 10/19/2017

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: Berkshire Farms became involved as the outside Preventive agency in May of 2018.				

Preventive Services History

MGM, BM, & BM's siblings were involved in 3 Preventive cases. From 11/6/06-10/14/08, and again from 6/17/09-5/31/11, services initiated following IND reports and neglect petitions. In both instances, services were court-ordered stemming from CPS concerns identified during investigations. The most recent case was in 2017.

The first case involved the MGM & the CHN's father (MGF). They were to obtain drug evaluations and refrain from use; parenting classes were also provided to MGM. There were times when participation declined. Eventually the case closed when MGM no longer wanted services and MGF had completed his COS and was given custody of the CHN.

The second case involved the MGM & the youngest child's father. Concerns continued to escalate and additional CPS reports were made and IND. The CHN were removed and services were mandated. MGM eventually participated and succeeded in completing services, resulting in the youngest MU being returned to her care; his father did not participate. BM and her 2 other siblings were in the care of MGF; no services were provided to him.

The case that remained open at the time of this writing began 10/19/17 due to concerns in a CPS report and a new neglect petition against MGM. MGM was to participate in services and ordered to comply with an OP. Following an admission in court, MGM was ordered to remain under the supervision of DCDCFS.

Foster Care Placement History

The BM and her 3 siblings were removed per court order on 7/31/09. A neglect petition had been filed 1 month prior due to CPS concerns. A removal ensued when court-ordered services and an OP were not being followed. The CHN were placed in a foster home. BM and 2 of her siblings were returned to the care of their father, MGF, on 8/26/09. BM's youngest sibling remained in Foster Care due to continued concerns regarding his mother (MGM) and father. While the CHN were in Foster Care, DCDCFS tried to engage MGM and the father of the youngest sibling in their court-ordered services, though the father chose to remain living out of state. A finding of neglect was made against the parents. The youngest sibling was placed on trial discharge back with MGM on 12/2/10, as MGM was engaging in services. Services included parenting classes, Family Treatment Court, and substance abuse treatment. The Foster Care Services case was closed 5/31/11, when all CHN were back in MGM's care – she had completed all court-ordered services, and displayed appropriate skills to adequately care for the CHN.

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:**
10/19/2017	There was not a fact finding	Adjourned in Contemplation of Dismissal (ACD)
Respondent:	047082 Grandparent Female 33 Year(s)	
Comments:	A Neglect Petition was filed on 10/19/2017 against MGM regarding concerns she was allowing BM and her boyfriend (BF) to engage in a sexual relationship in her home for over a year, and admitted to not seeing the reason for concern. The Judge issued an OP that MGM was to follow, to prohibit contact between the CHN. In follow-up court appearances, BM's MH was addressed, and the need to seek Tx. The case was adjourned in contemplation of dismissal following an admission and an agreement to follow the court order which was issued.	

Have any Orders of Protection been issued? Yes	
From: 10/19/2017	**To:** Unknown
Explain: In response to concerns in a Neglect Petition which was filed on this date regarding MGM's allowance of a sexual relationship between BM and BF, an OP was issued with which MGM was to comply - No contact between BM and BF.	

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