Child Fatality Report

Report Identification Number: RO-17-043

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

Issue Date: Jun 06, 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: 10 day(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 11/13/2017
Initial Date OCFS Notified: 11/13/2017

Presenting Information

An SCR report was received which alleged that on 11/13/17, a 10-day-old child, who was otherwise healthy, drowned in the bathtub of the home while he was fully clothed. The mother and father were the child's caregivers. The circumstances surrounding the child's death were suspicious and it was an unknown who was caring for him at the time. The father found the child unresponsive in the bathtub and called 911. The child could not be saved and was pronounced dead at 3:12PM.

Executive Summary

This fatality report concerns the death of a 10-day-old male child (SC) that occurred on 11/13/17. An SCR report was made the same day alleging the child had drowned and died while in the home of his mother and father. The parent substitute (PS) was incorrectly named the father in the SCR report. There was a 7-year-old surviving sibling living in the home who was in school at the time of the incident. PS is the father of the 7yo SS. PS was also the father of a 2-year-old surviving sibling who did not reside in the home. The 2-year-old surviving sibling was not seen and assessed during this investigation. The child lived with her mother and had never met the SC.

Since 2012, the mother was involved in 6 CPS cases which all had serious safety concerns for her child(ren). MCDHS frequently failed to address these safety concerns and continued to track these cases as FAR, which repeatedly proved to be ineffective. It was not appropriate to track these cases in FAR as in several cases, the child(ren) needed safety plans. In two of the cases, mother was arrested for endangering the welfare of a child and orders of protection were put in place. Mother repeatedly proved to be non-compliant with her mental health treatment and incapable of providing a minimum degree of care to her child(ren). Throughout the family's involvement with CPS, there were consistent concerns with the mother's lack of compliance with her mental health treatment, domestic violence, drug & alcohol abuse, lack of appropriate housing, and that the mother may have been suffering from a traumatic brain injury. MCDHS consistently failed to make efforts to provide and engage the family with services and treatment. On 11/3/17 during the most recent FAR case prior to the fatality, the mother admitted to using cocaine on 11/2/17 and said the voices in her head made her do it. On 11/6/17, the mother told the caseworker (CW) she was hearing voices that wanted to hurt her and admitted that years ago, she stabbed herself in the foot because the voices told her to hurt herself. In the case record of that incident from 2/16/17, mother told the caseworker the voices in her head told her to hurt her 7-year-old daughter (who was 6 years old at the time). MCDHS failed to create an adequate safety plan for this newborn child. Over the course of this family's CPS involvement, MCDHS repeatedly failed to adequately assess safety and address safety and risk concerns. Case records show there was a significant lack of supervisory oversight and a lack of recognition to the seriousness of this family's issues. The severity and complexity of the mother's mental health needs were known to MCDHS since 2015. MCDHS had extensive documentation of the mother's compromised ability to supervise and protect her child(ren) and failed to act. MCDHS records did not reflect if consultations with their legal department took place or if consideration to pursue Family Court action was considered, even though MCDHS had a tremendous amount of documentation that would have justified them doing so.

Monroe County Department of Human Services (MCDHS) coordinated efforts with LE upon receipt of the fatality report. CW received records from LE, EMS, and the hospital regarding SC's death. An autopsy was performed; however, the record did not reflect the CW had received an autopsy report or discussed any preliminary findings with the ME.

Bereavement services and burial assistance were not offered to the family. The mother's attorney prohibited her from

speaking with MCDHS.

Diligent efforts were made to locate and contact SC's father but efforts were unsuccessful.

The allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision against the mother were substantiated, and the allegations were unsubstantiated against PS. The mother had a long history of mental health issues which included auditory hallucinations. The mother said that on 11/13/17, voices told her to hurt her child by putting him in the bathtub. The mother admitted she placed the child in the bathtub, watched him roll over onto his stomach, and she walked away making no efforts to save the child. The mother admitted the child's incessant crying bothered her and she never thought to wake PS, who was sleeping at the time, and ask for his help. The case was indicated and closed on 2/23/18 and referred to community based services only.

The mother was criminally charged with 2nd degree murder and remained in jail awaiting court proceedings at the time of case closing.

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

Explain:
There was a problem with Connections and that is why the 24 hour safety assessment was not submitted until 11/15/17.

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?** Yes

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:
Casework activity was commensurate with case circumstances in the fatality investigation; however, it did not appear bereavement counseling or assistance with burial costs were offered to the PS and SS1.

Required Actions Related to the Fatality

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

Issue:	Review of CPS History
Summary:	This SCR report was received on 11/13/17 and the CPS history search was not completed until 11/15/17.
Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	Within 1 business day of the oral report date, the child protective service must review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded and FAR reports where the current report involves a subject of the unfounded or FAR report, a child named in the unfounded or FAR report or a child's sibling named in the unfounded or FAR report.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	There were some case notes that were entered up to 3 months after the event date.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/13/2017 **Time of Death:** Unknown

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

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 02:43 PM
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

☐ Drug Impaired ☐ Absent
☐ Alcohol Impaired ☐ Asleep
☐ Distracted ☒ Impaired by illness

☐ Impaired by disability ☐ Other: mental illness

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	Male	10 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)

LDSS Response

MCDHS initiated the investigation of the 11/13/17 report within 24 hours, coordinating efforts with LE. MCDHS contacted the source of the report and notified the ME and DA of SC's death. A SS who lived in the home was in school at the time of the fatality. A CPS history search was conducted on 11/15/17.

CW visited SM's home on 11/13/17 and a safety plan was made for the SS. CW then observed LE's interview with SM. SM said after SS went to school that day, she fed SC a bottle between 8:45-9AM. SC was crying and it bothered her. SM reported SC continuously cried but she never thought to wake PS and ask for help. SM said she heard voices nearly daily; they wanted SC's soul and told her what to do. They told her to hurt SC by putting him in the tub with deep water. She placed SC in the tub on his back, watched him roll over to his stomach, and did nothing. The voices told her to place all of SC's things in his Pack 'N Play so she did. SM said PS was sleeping in the living room the whole time. SM said SC was in the tub for 1-2 hours and she saw blood come from his nose at one point. SM said SC is at peace now and is where he needs to be.

When interviewed, PS said he had been sick and went back to sleep after SS went to school that morning. PS awoke around 2PM and saw the home had been cleaned and all of SC's items were in his Pack 'N Play. PS looked around the home for SM but did not see her; he did not look in the bathroom. PS stepped outside and saw SM walking down the street back into the home. PS said he asked SM where the baby was and she said "don't worry the baby is safe in the tub." PS ran to the bathroom and found SC face down in the tub. PS told SM to start CPR while he called 911. PS said he was not the father of SC so he did not do a lot of the caretaking for him. He had recently gotten back together with SM and started staying with her because he was worried about her caring for SS1. CW spoke with PS about not allowing SM to have unsupervised contact with SS; he agreed. PS did not have contact information for SC's father. PS planned to take SS to one of his parent's homes. PS agreed to services offered to help him.

On 11/13/17, CW visited SS at her PGGF's home to assess her safety. SS was visibly upset but appeared safe and comfortable in his home.

On 11/4/17 CW interviewed SS. She said on 11/13/17, she got ready for school and saw her brother in SM's room crying. SS said crying was normal for SC and he always cried. SS left the home that morning to wait for her school bus. SS said neither parent drank alcohol or used drugs. She had never witnessed her parents fight. SS said sometimes SM would seem sad but she was not sure when she last saw SM sad.

Several relatives were interviewed and were aware SM had mental health issues but not of the extent. PS said SM began having MH issues after she was involved in a car accident 2 years ago. SM claimed she suffered a traumatic brain injury. SM's attorney would not allow CW to interview SM.

CW obtained medical records and spoke with hospital staff. Medical records showed SM had a lengthy history of serious MH issues. CW reviewed a journal SM kept where she often discussed the voices in her head. Medical records showed SM had weekly MH appointments in 2017. During almost every appointment, SM reported having visual and/or auditory hallucinations. During an appointment on 11/7/17, SM reported hearing voices that the BF wanted SC's soul. The record indicated the hospital psychiatrist evaluated SM and approved her to go home with her baby; her baseline was "psychotic." Although there was an open investigation and a lengthy history with the family, there was no documentation if further explanation was sought to say it was safe for the mother to be the primary caretaker of a newborn.

At the close of this case, SM remained in jail, SS was in the care of her father (PS), and the 2yo SS remained in the care of her mother. PS was referred to community based services.

Official Manner and Cause of Death

Official Manner: Homicide
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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042361 - Deceased Child, Male, 10 Days	042362 - Mother, Female, 25 Year(s)	Lack of Supervision	Substantiated
042361 - Deceased Child, Male, 10 Days	042363 - Mother's Partner, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated
042361 - Deceased Child, Male, 10 Days	042363 - Mother's Partner, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
042361 - Deceased Child, Male, 10 Days	042362 - Mother, Female, 25 Year(s)	DOA / Fatality	Substantiated
042361 - Deceased Child, Male, 10 Days	042362 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
042361 - Deceased Child, Male, 10 Days	042363 - Mother's Partner, Male, 26 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐
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:
There were several progress notes that were not entered contemporaneously, including an interview with the SS that took place on 11/14/17 and was not entered until 2/16/18.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☒	☐	☐	☐
Explain: Safety was not adequately assessed in this case.				
When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The 7yo SS was safe in the care of her father who had many familial supports and her mother was in jail.				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Mother	Unknown	Unknown
Comments:	Mother remained in jail awaiting court proceedings at the close of the investigation.		

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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/03/2017	Deceased Child, Male, 2 Hours	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Far-Closed	Yes

Report Summary:
SM gave birth to a son on 11/3/17. SM had a positive toxicology for cocaine at delivery. The newborn's toxicology results were unknown. It was unknown if the newborn had any withdrawal symptoms. SS had an unknown role.

OCFS Review Results:
Notice of the FAR report was sent 4 days late to all parties.

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

Issue:
FAR-Failure to Provide Notice of Report
Summary:
Notification was provided 4 days late to all parties.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
No later than seven days after receipt of a child protective report that the has been assigned to the family assessment response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Issue:
FAR-Inappropriate Determination of CPS/FAR Track
Summary:
This case was incorrectly tracked FAR. SM had a lengthy history of MH issues, criminal arrests, and CPS cases with serious safety concerns. SM reported using cocaine the day before delivering SC and was also actively hearing voices. There was a need for a safety intervention, which would have made the case ineligible for FAR tracking. The severity of the safety factors, age and vulnerability of the child(ren) must be considered when deciding to track FAR. SM did not have an adequate support system and a safety plan was needed. The record did not reflect verification that SM was actively involved in community based services, or had adequate support from friends or family.
Legal Reference:
18 NYCRR 432.13 (c); 18 NYCRR 432.13(e)(2)(ii)(a-d)
Action:
MCDHS will evaluate safety concerns, review history, and evaluate all case circumstances to determine if a FAR track is appropriate.

Issue:
FAR-Timely/Adequate 7-Day Assessment
Summary:
MCDHS did not complete an adequate safety assessment within 7 days of receiving this report. On 11/6/17, SM told CW she was actively hearing voices that wanted to hurt her. In the past she stabbed herself in the foot because the voices told her to hurt herself. The 11/7/17 safety assessment was inaccurate in that safety decision 3 should have been chosen to show a safety plan was needed. Even though SM was cleared to be discharged by medical professionals at the hospital, they did not provide long term care for her and were unaware of her MH history. SM claimed to be involved with community based services but the record did not reflect this was verified. SM did not appear to have a support system. SM's mother lived out of state, the record did not reflect SM had any friends, and the father of the SS only started staying at the home because he was worried about his daughter being in the sole care of SM. SM had a MH appointment

scheduled for 11/7/17 and it was not verified she attended until 11/13/17. There was no discussion held with the father of SS about a safety plan for SC.

Legal Reference:

18 NYCRR 432.13 (d)(2)(i) and (ii); 18 NYCRR 432.13(d)(3)

Action:

Safety will be adequately assessed and documented in safety assessments. Safety plans will be implemented when there are concerns of impending danger.

Issue:

FAR-Failure to Address Reported or Identified Concerns

Summary:

MCDHS had an overwhelming amount of evidence showing SC would be at risk of harm in the sole care of his mother. MCDHS failed to make a plan for SC to be safe in the care of his mother. While mother stated she was involved in many community based services, the record does not reflect the caseworker spoke with these supports to verify she was actively involved.

Legal Reference:

18 NYCRR 432.13 (a)(3)(iii)

Action:

In the FAR track, CPS must first establish that children in the family named in the report are safe; and provide ongoing assessment of safety and risk.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/01/2017	Sibling, Female, 6 Years	Other Adult - PS's Partner, Female, 24 Years	Inadequate Guardianship	Far-Closed	Yes
	Other Child - PS's Partner's Daughter, Female, 3 Years	Other Adult - PS's Partner, Female, 24 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 2 Years	Other Adult - PS's Partner, Female, 24 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 6 Years	Mother's Partner, Male, 26 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 2 Years	Mother's Partner, Male, 26 Years	Inadequate Guardianship	Far-Closed	
	Other Child - PS's Partner's Daughter, Female, 3 Years	Mother's Partner, Male, 26 Years	Inadequate Guardianship	Far-Closed	

Report Summary:

It was alleged there was a history of physical altercations between PS and his girlfriend (OA) while in the presence of SS, the 2yo SS, & OC. During past altercations, PS had thrown and damaged household items and OA had hit PS. During a past altercation, OA threw pots and pans and SS was struck by one of them. It was unknown if SS sustained a visible injury. It was unknown if the 2yo SS & OC had sustained any injuries, but the altercations resulted in orders of protection. Also in the past, OA pinched SS out of anger; it was unknown if she sustained an injury. SM had an unknown role. PS and OA had one child in common, the 2yo SS. OA had a daughter (OC) not related to SC.

OCFS Review Results:

Some progress notes were entered over a month late.

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

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Some progress notes were entered up to 1 month after the event date.

Legal Reference:

18 NYCRR 428.5(a) and (c)

Action:

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/16/2017	Sibling, Female, 6 Years	Mother, Female, 24 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Female, 6 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 6 Years	Mother's Partner, Male, 25 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 6 Years	Mother's Partner, Male, 25 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 6 Years	Father, Male, 30 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 6 Years	Father, Male, 30 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:

It was alleged the SM and BF were abusing marijuana, cocaine, and alcohol while caring for SS1. BF had been physically violent with SM while SS1 had been in the home. SM was hallucinating and hearing voices telling her to hurt others. SM was non-compliant with her medication. PS had also been physically violent with SM in the presence of SS1. PS had left SS1 home alone at times while he ran errands.

OCFS Review Results:

Notification letters were sent late and progress notes were entered 2 months late. This case was not FAR eligible. SM admitted her and BF were using cocaine while caring for SS1, SM was hallucinating and heard voices telling her that SS1 was in danger. SM was non-compliant with her MH medication and said the medication does not help. Family had not benefitted from the previous FAR cases. SM also admitted physical DV occurred in the presence of SS1. SM admitted to stabbing herself in the foot in the past because the voices in her head told her to do something to end her pain. SS1 was in the home at the time of this incident. MCDHS did not consult legal during this investigation.

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

Issue:

FAR-Failure to Provide Notice of Report

Summary:

Notification of the report was not provided to the SM, BF, and PS within the first 7 days upon receipt of the report.

Legal Reference:

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

Action:

No later than seven days after receipt of a child protective report that the has been assigned to the family assessment response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Some progress notes were entered up to 2 months after the event date.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:
FAR-Inappropriate Determination of CPS/FAR Track
Summary:
This case was incorrectly tracked FAR. SM had a lengthy history of MH issues, criminal arrests, and CPS cases with serious safety concerns. On 2/16/17, MCDHS was made aware of SM's disclosure of hearing voices telling her to hurt others and that she had been using cocaine while caring for SS1. SM also admitted to physical DV in the presence of the child.
Legal Reference:
18 NYCRR 432.13 (c); 18 NYCRR 432.13(e)(2)(ii)(a-d)
Action:
MCDHS will evaluate safety concerns, review history, and evaluate all case circumstances to determine if a FAR track is appropriate.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/27/2016	Sibling, Female, 5 Years	Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Far-Closed	Yes
	Sibling, Female, 5 Years	Mother, Female, 24 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 5 Years	Mother's Partner, Male, 25 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 5 Years	Mother's Partner, Male, 25 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
It was alleged the PS and SM were failing to make an adequate plan for the continued care of the SS. Two weeks before the report, PS was unreachable for approximately 5 days and did not make a plan for SS's care. SM was not supposed to have caretaking responsibility of SS due to an incident where she injured SS in April 2016. PS continued to leave SS with SM despite knowing she was not supposed to care for SS. Neither PS or SM had food for SS and as a result, SS went without food for days at a time.

OCFS Review Results:
The notification letters were not sent to SM and PS until 9/20/16 (almost 2 months late). The record did not reflect a history search was performed during this investigation. Even though SM had mentally decompensated to the point where

she admitted herself in to the hospital for MH issues, she tested positive for cocaine, and was in violation of an OP by having unsupervised visits with SS, MCDHS did not consult with their legal department.

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

Issue:
FAR-Failure to Provide Notice of Report
Summary:
Notification of the report was not provided to the SM and PS until 2 months after the receipt of the report.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
No later than seven days after receipt of a child protective report that the has been assigned to the family assessment response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Issue:
Review of CPS History
Summary:
The record did not reflect a history search was performed during this investigation.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of the oral report date, the child protective service must review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded and FAR reports where the current report involves a subject of the unfounded or FAR report, a child named in the unfounded or FAR report or a child's sibling named in the unfounded or FAR report.

Issue:
Assessment as to need for Family Court Action
Summary:
This was a subsequent report with continued concerns of safety for the child. The record did not reflect MCDHS consulted with legal or considered Family Court action even though the case record documented the child was not safe in the care of either parent. SM had untreated MH issues and had hit the child with a hammer in the initial investigation. There was a no contact order of protection in place except visitation as agreed upon. The order said the visits were supposed to be supervised. PS left the child in SM's care unsupervised. SM was using drugs and tested positive for cocaine and continued to mentally decompensate.
Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)
Action:
CPS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/14/2016	Sibling, Female, 5 Years	Mother, Female, 23 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Female, 5 Years	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
It was alleged that on 4/13/16 at 10:40PM, SM was intoxicated and charged after PS with a hammer while in the direct presence of SS. It was unknown if SF or SS sustained physical injuries. The role of PS was unknown at the time.

OCFS Review Results:
Progress notes were not entered contemporaneously; some notes were entered up to 5 months after the event date. Notification letters to SM and PS were sent a month late on 5/13/16. CPS history was not reviewed until 6/9/16 and said there was no relevant information found. SM was arrested for a mental health arrest and endangering the welfare of a child. The child sustained a small abrasion on her arm. An OP was put in place for the child. Safety decision #3 should have been selected as a safety plan was necessary, making this care ineligible for FAR.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
There were case notes that were entered up to 5 months late.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:
FAR-Failure to Provide Notice of Report
Summary:
Notification to SM and PS was provided 1 month late.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
No later than seven days after receipt of a child protective report that the has been assigned to the family assessment response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Issue:
Review of CPS History
Summary:
CPS history was reviewed 2 months after the receipt of the report and did not include pertinent information relevant to the ongoing concerns.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of the oral report date, the child protective service must review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded and FAR reports where the current report involves a subject of the unfounded or FAR report, a child named in the unfounded or FAR report or a child's sibling named in the unfounded or FAR report.

Issue:
FAR-Inappropriate Determination of CPS/FAR Track
Summary:

This case was inappropriately tracked FAR. SM was arrested and charged with endangering the welfare of a child. There needed to be a safety plan made for SS. According to MCDHS guidelines for tracking a report to FAR, the need for a safety plan makes a case ineligible for FAR.

Legal Reference:

18 NYCRR 432.13 (c); 18 NYCRR 432.13(e)(2)(ii)(a-d)

Action:

MCDHS must follow it's written protocol to decide whether or not a case is eligible to be tracked FAR.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/06/2016	Sibling, Female, 5 Years	Mother, Female, 23 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Female, 5 Years	Mother's Partner, Male, 24 Years	Inadequate Guardianship	Far-Closed	

Report Summary:

The report alleged SM and PS have been involved in physical altercations where they hit each other in the presence of their 5-year-old daughter (SS).

OCFS Review Results:

SM, PS, and SS denied any physical DV. SM went into the hospital because she stabbed herself in the foot. SM claimed to have been in a bad car accident on 5/9/15 and claimed to suffer a traumatic brain injury. SM claimed since the accident she had difficulty with her memory and would become easily angered. CW did not follow up with a collateral about this. During a home visit, SM was observed to be heating the home with the oven as her electric had been turned off for non-payment. SS had asthma and was unable to use her electric pump as a result. SS had been sick with a fever for 2 days. There was no documented resolution to the electricity concern. SM was evicted from her home in the past.

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

Issue:

FAR-Failure to Address Reported or Identified Concerns

Summary:

A home visit was made on 2/4/16, the family had no heat or electricity in the home and these concerns were not addressed. SM had been heating the home by turning the oven on and leaving the oven door open. SM stated she paid half the bill so the electricity would be turned on the next day. The record did not reflect an attempt to verify the bill was paid. Another home visit was not completed until 2/23/16.

Legal Reference:

18 NYCRR 432.13 (a)(3)(iii)

Action:

MCDHS will partner with the family to assist the family in obtaining goods and services that will help the family meet its identified needs regarding care of the children, thereby reducing future risk of abuse or maltreatment of a child or children.

Issue:

FAR-Failure to Offer and/or Provide Needed Services

Summary:

The family had no heat or electricity in the home and MCDHS failed to offer appropriate services. SM reported to have suffered a traumatic brain injury as the result of a car accident, and as a result she had difficulty with her memory and would become easily angered.

Legal Reference:

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

Action:

When family needs are identified, workers must offer to work jointly with the family to develop and implement solutions to address their needs.

[redacted]

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

12/4/12-2/25/13 (FAR)- allegations of IG, LS & IF/C/S against SM for SS1. SM left SS1 home alone while she went to class at community college. SS1 was home alone for at least 3 hours. SM lost her keys and was unable to get back into the home so she contacted the police. SM was arrested for endangering the welfare of a child.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No