Child Fatality Report

Report Identification Number: RO-17-019

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

Issue Date: Nov 22, 2017

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: 5 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 06/08/2017
Initial Date OCFS Notified: 06/08/2017

Presenting Information

In the early morning hours on 6/8/17, SM consumed several alcoholic beverages. At approximately 2AM, SM tended to 5-month-old SC who was crying, and sat on the couch with her. SM proceeded to fall asleep with SC, and awoke several hours later to find SC in-between SM and the couch cushion; SC was not breathing and unresponsive. EMS responded to the home and at 8:53AM, SC was pronounced dead. It was unknown if SM drank to the point of intoxication, or what the roles of SF and SS were at the time of the incident.

Executive Summary

This fatality report concerns the death of a 5-month-old female (SC) that occurred on 6/8/17. A report was made to the SCR on that same date with allegations of DOA/Fatality and IG against SM regarding SC. A subsequent report was received on 7/6/17 with allegations of IG, LS, and PD/AM against SM and SF regarding the four SS, ages 9, 6, and 2 years old (twins). Monroe County Department of Human Services (MCDHS) conducted an investigation surrounding SC's death. Neither a Death Certificate nor final autopsy report were available for review at the time of this writing.

SM and SF reported SC was born healthy with no pre-existing medical conditions. SM and SF had four other children that were observed and assessed throughout the fatality investigation.

It was discovered on the night of 6/7/17, SC was reported to have had symptoms of a cold. SM had fallen asleep on a couch while holding SC, due to SC not feeling well, from approximately 11PM until 8AM the following morning. SM admitting to having several alcoholic beverages throughout the night preceding the fatality, but denied intoxication. SF denied having any alcohol that evening, and both parents denied the use of drugs. It was not determined if SM and SF were educated surrounding safe sleep practices, but MCDHS did observe safe sleep provisions in the home that were full of items; MCDHS did not address this with the parents. Interviews with the SS revealed SM and SF would regularly sleep in their bed with SC. There were no further details documented as to when or how SC was found unresponsive or how SM and SF responded. The case record reflected several detailed supervisory notes which described what questions and concerns needed to be discussed with the family throughout the investigation; however, there was no documentation that the caseworker followed up with much of this direction. All appropriate collateral contacts were not spoken to, and not all assessments and reports were submitted timely.

From the time the investigation began to the time of this writing, MCDHS met with all family members and interviewed SM, SF, and the verbal SS; the younger SS were observed and all children were assessed to be safe. MCDHS referred the family to grief and trauma services, which they accepted and began to engage in. At the time of this writing, the fatality investigation remained open, and the autopsy remained pending. There were no criminal charges as a result of SC's death.

Review of this investigation resulted in several citations related to overall casework practices. In response, MCDHS will submit a Program Improvement Plan (PIP) to the 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?** Unable to Determine
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The case had not yet been determined at the time of this writing.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The case remained open at the time of this writing.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 7 Day Safety Assessment was due on 6/15/17, but not completed and approved until 9/12/17.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	Rochester Regional Office is aware of the above concern, and there is a plan in place that is outlined in MCDHS's current PIP to address such.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30 Day Fatality Report was due on 7/8/17, but not completed and approved until 7/20/17.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	Rochester Regional Office is aware of the above concern, and there is a plan in place that is outlined in MCDHS's current PIP to address such.

Issue:	Adequacy of face-to-face contacts with the child and/or childs parents or guardians
Summary:	Details surrounding the events the morning SC was found unresponsive were not gathered by MCDHS. Appropriate follow-up was not conducted regarding safe sleep education, discipline, or marijuana found in the home.
Legal Reference:	432.1 (o)
Action:	MCDHS will adequately explore all concerns that come up during an investigation via interviews with parents and/or children.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/08/2017 **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: 09:16 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:

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	5 Month(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	9 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	6 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	33 Year(s)

LDSS Response

On 6/8/17, MCDHS received an SCR report regarding the death of SC. MCDHS initiated their investigation within 24 hours, and coordinated their efforts with LE. A conversation between MCDHS and LE noted SM had admitted she engaged in alcohol use on the night of 6/7/17. LE also noted when they responded to the home, there was a smell of marijuana. On 6/8/17, MCDHS completed a home visit accompanied by LE, to assess for safety. The home was found to be dirty/cluttered, but not a safety hazard. A Pack and Play, crib, and bassinet were observed to be full of items and it appeared they were not being used. LE took photos of the scene, and MCDHS was able to review the 911 calls. On this same date, a second home visit was conducted by MCDHS. MCDHS offered the family grief and trauma services, which they accepted, and the SS were seen and assessed as safe. A plan was implemented where MGM was to stay with SM and the SS to assist with childcare and ensure SM refrained from drug and alcohol use around the SS; SF was not involved in the plan for undocumented reasons.

On 6/14/17, MCDHS interviewed the SS, SF, SM at the Monroe County CAC. SM reported to MCDHS that she drank alcohol on the night of 6/8/17, but could not remember how much and denied intoxication. In a later interview, SM reported she drank “probably too much”. SF denied drinking alcohol that night. Both parents denied the use of drugs. SF reported when he went to sleep that night, he saw SC in her bassinet while SM was asleep on the couch. SF reported he awoke at approximately 8AM the next morning and found SM sleeping with SC next to her on the couch; SC was horizontal across the top of the chaise, while SM was asleep on the right side of the chaise. Interviews with the SS revealed SC would sleep in between SM and SF in their adult bed regularly. The next home visit occurred on 7/3/17. During this visit, SM reported to MCDHS that SC appeared to have a cold around the time of her death, with a stuffy nose; SM fell asleep on the couch while holding SC, because SC did not feel well. At no point during the investigation did MCDHS gather any details from the family about when they found SC unresponsive, what position SC was in, or what occurred after that discovery. There was also no conversation with SM or SF regarding safe sleep practices, or if they were ever educated surrounding such. MCDHS did not follow up with SM and SF about the concern of possible marijuana use, being that first responders smelled marijuana in the home, and remnants of marijuana were also observed. The SS had mentioned SM “taps” them with a belt as punishment on occasion, but MCDHS did not have a further conversation with SM or SF about this. MCDHS did request and receive medical records from the hospital where SC was pronounced deceased. The record did not reflect any conversations between MCDHS and medical staff or the ME regarding SC’s possible cause and manner of death or if there were any immediate concerns found.

A subsequent report was made to the SCR on 7/6/17, with concerns SM and SF were using drugs and alcohol to the point of impairment while caring for the SS and not supervising the SS. MCDHS addressed these allegations with SM and SF and found no validity to the concerns. MCDHS appropriately consolidated the subsequent report into the fatality investigation.

As part of the fatality investigation, MCDHS conducted a CPS history check, sent Notice of Existence letters, and completed the 24-Hour assessments timely; however, additional required assessments and reports were not submitted by their due dates. At the time of this writing, the investigation remained open, and the family was actively engaged in grief and trauma services

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

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
041662 - Deceased Child, Female, 5 Mons	041663 - Mother, Female, 29 Year(s)	DOA / Fatality	Pending
041662 - Deceased Child, Female, 5 Mons	041663 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Pending
041665 - Sibling, Female, 9 Year(s)	041664 - Father, Male, 33 Year(s)	Inadequate Guardianship	Pending
041665 - Sibling, Female, 9 Year(s)	041663 - Mother, Female, 29 Year(s)	Parents Drug / Alcohol Misuse	Pending
041665 - Sibling, Female, 9 Year(s)	041663 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Pending
041665 - Sibling, Female, 9 Year(s)	041663 - Mother, Female, 29 Year(s)	Lack of Supervision	Pending
041665 - Sibling, Female, 9 Year(s)	041664 - Father, Male, 33 Year(s)	Parents Drug / Alcohol Misuse	Pending
041665 - Sibling, Female, 9 Year(s)	041664 - Father, Male, 33 Year(s)	Lack of Supervision	Pending
041666 - Sibling, Female, 6 Year(s)	041664 - Father, Male, 33 Year(s)	Lack of Supervision	Pending
041666 - Sibling, Female, 6 Year(s)	041663 - Mother, Female, 29 Year(s)	Lack of Supervision	Pending
041666 - Sibling, Female, 6 Year(s)	041664 - Father, Male, 33 Year(s)	Parents Drug / Alcohol Misuse	Pending
041666 - Sibling, Female, 6 Year(s)	041663 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Pending
041666 - Sibling, Female, 6 Year(s)	041663 - Mother, Female, 29 Year(s)	Parents Drug / Alcohol Misuse	Pending
041666 - Sibling, Female, 6 Year(s)	041664 - Father, Male, 33 Year(s)	Inadequate Guardianship	Pending

041667 - Sibling, Male, 2 Year(s)	041664 - Father, Male, 33 Year(s)	Inadequate Guardianship	Pending
041667 - Sibling, Male, 2 Year(s)	041663 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Pending
041667 - Sibling, Male, 2 Year(s)	041663 - Mother, Female, 29 Year(s)	Lack of Supervision	Pending
041667 - Sibling, Male, 2 Year(s)	041664 - Father, Male, 33 Year(s)	Parents Drug / Alcohol Misuse	Pending
041667 - Sibling, Male, 2 Year(s)	041664 - Father, Male, 33 Year(s)	Lack of Supervision	Pending
041667 - Sibling, Male, 2 Year(s)	041663 - Mother, Female, 29 Year(s)	Parents Drug / Alcohol Misuse	Pending
041668 - Sibling, Female, 2 Year(s)	041664 - Father, Male, 33 Year(s)	Inadequate Guardianship	Pending
041668 - Sibling, Female, 2 Year(s)	041663 - Mother, Female, 29 Year(s)	Parents Drug / Alcohol Misuse	Pending
041668 - Sibling, Female, 2 Year(s)	041663 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Pending
041668 - Sibling, Female, 2 Year(s)	041663 - Mother, Female, 29 Year(s)	Lack of Supervision	Pending
041668 - Sibling, Female, 2 Year(s)	041664 - Father, Male, 33 Year(s)	Parents Drug / Alcohol Misuse	Pending
041668 - Sibling, Female, 2 Year(s)	041664 - Father, Male, 33 Year(s)	Lack of Supervision	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☐	☒	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
School	☐	☒	☐	☐
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 appropriate collateral contacts.

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?	☒	☐	☐	☐

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: At the time of this writing, the RAP was not yet completed.				

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: There were no SS removed as a result of this fatality.				

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	Needed but 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:
The family was offered some services in response to the SC's death. Funeral assistance, parenting skills and homemaking services may have been useful to the family, but were not offered by MCDHS. SM declined a referral for substance abuse treatment.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
A services case was opened in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief and bereavement services were offered to all family members. A services case was opened in response to the fatality.

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
- ☐ 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)
07/30/2015	Sibling, Female, 7 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 11 Months	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Female, 4 Years	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unfounded	

Sibling, Female, 11 Months	Mother, Female, 27 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 11 Months	Mother, Female, 27 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 11 Months	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unfounded
Sibling, Female, 7 Years	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unfounded
Sibling, Female, 4 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unfounded

Report Summary:
This report was received with concerns SM drank alcohol and smoked marijuana to excess and then tried to stab herself with a knife in the presence of her four children, ages 7, 4, and 11 month old (twins). SM was taken to the hospital. SF did not reside in the home and his role was unknown.

Determination: Unfounded | **Date of Determination:** 09/25/2016

Basis for Determination:
MCDHS conducted interviews with SM, SF, the two older SS, and family members present on the date of the incident. It was discovered SM engaged in a verbal/physical altercation with MA, while both were under the influence of drugs and alcohol. Further, it was found as a result of this fight, SM threatened to stab herself with a knife; she was remanded by LE under mental hygiene laws and taken to the hospital. MCDHS unfounded the report noting the SS were present during some of the incident, but it did not cause any significant impairment to them. MCDHS also noted the behavior was not an on-going issue.

OCFS Review Results:
Review of this investigation found MCDHS did not recommend SM engage in a substance abuse evaluation, despite SM and other family members stating concern regarding SM's drinking. MCDHS found SM had multiple serious MH diagnoses. The hospital referred SM for MH treatment, which SM began attending. MCDHS never followed up with the provider where SM was referred. MCDHS had no contact with the family from 7/31/15 until 6/17/16. On 6/17/16, MCDHS was informed by SM she had chosen not to engage in MH treatment, and she was also pregnant again. The RAP was completed inaccurately. MCDHS offered community based services, which SM and SF denied.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP was completely inaccurately. For the question pertaining to abusive or threatening incidents with partners or other adults, MCDHS selected "No". The answer to this question regarding SM should have been yes, because of the physical altercation that took place between SM and MA.

Legal Reference:
18 NYCRR 432.2(d)

Action:
MCDHS will complete RAPs accurately.

Issue:
Failure to Offer Services

Summary:
MCDHS did not recommend SM attend a substance abuse evaluation, despite SM stating she drank too much and also used marijuana.

Legal Reference:

SSL 424(10); NYCRR 428.6

Action:

MCDHS will offer all appropriate services to families.

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

MCDHS did not have any contact with the family for almost an entire year, while the investigation remained open. MCDHS also failed to follow up with the mental health provider that SM was referred to by the hospital.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

Action:

MCDHS will continually assess risk and safety of children on all open CPS investigations. MCDHS will follow up with appropriate collateral contacts.

[redacted]

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

There is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

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

Additional Local District Comments

This fatality report has been reviewed and it is factually correct.

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