Child Fatality Report

Report Identification Number: RO-18-014

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

Issue Date: Sep 05, 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: 23 day(s)
Jurisdiction: Ontario
Gender: Male
Date of Death: 07/02/2015
Initial Date OCFS Notified: 05/08/2018

Presenting Information

An SCR report received on 05/07/18 alleged that 3 years ago, the subject mother was co-sleeping with her 3-week-old male child in her bed. The subject mother rolled over on top of the child resulting in the subject child's death. It was unknown where the father and the then 2 year old surviving sibling were at the time of the incident. The subject mother continued to co-sleep with the surviving sibling. The grandmother had an unknown role.

Executive Summary

This report concerns an SCR report received on 05/07/2018 regarding the death of the 23-day-old male SC. Approximately 3 years prior to the report, while living in another state, the SM co-slept with the SC and woke to find him unresponsive in her bed. The fatality report received by the SCR did not identify that the SC died in another state. The SC was an otherwise healthy child.

OCDSS promptly notified LE upon receiving notification of the SC's death, and they worked in conjunction with one another to obtain information from LE and CPS in Mississippi regarding the death. At the time of the death, the fatal incident was investigated by LE and the Mississippi Department of Human Services Division of Family and Children Services (MFCS), where the family was living at the time and where the death occurred. LE assisted in contacting LE in Mississippi to obtain records, but the records were not forthcoming.

The investigation revealed that on 07/02/15, the SM was exhausted with her new baby, SC, and placed the SC in bed with her and fell asleep. SM acknowledged she was made aware of safe sleeping practices, yet was sharing a bed with both the SC and the now 5yo SS.

Information received from MFCS documented that when the SM awoke, she was laying on top of the SC in the bed. The SC was unresponsive and the SM immediately made her mother aware, who called for EMS and administered CPR on the SC until EMS arrived. The SC was deceased upon the arrival of EMS.

OCDSS adequately assessed the safety of the now 5yo SS within 24 hours of receiving the report, and determined the SS was living with the SM and the MGM in Ontario County. The home presented no safety concerns and the SS was assessed to be safe in the care of his family.

OCDSS obtained the autopsy report from the Mississippi State Medical Examiner's Office and learned the Forensic Pathologist who completed the autopsy ruled the cause of death to be positional asphyxia and the manner of death accidental. Due to the investigation finding no evidence of criminality, no arrests were made.

Sufficient collateral contacts were made during the investigation with agencies in Mississippi. Although the MFCS' investigation found some credible evidence that the child's death was due to the actions of the SM, and this evidence was shared with OCDSS during the course of the investigation, the report was appropriately unfounded due to the incident taking place outside of New York State. Therefore, New York State did not have jurisdiction to make a determination regarding an incident that occurred out of state.

The SM continued to grieve the loss of the SC and received MH counseling through OCDSS prior to the investigation,

after moving to the area. In response to the fatality, OCDSS offered services to the SM and the MGM including continued MH counseling, family trauma intervention, and bereavement counseling, which were declined.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** 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 notes a consultation took place, but no details noted.

Explain:
OCDSS appropriately unfounded the allegations and closed the case.

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:	OCDSS did not complete a 7-day safety assessment in Connections until 6/6/18. The 7 day safety assessment was due to be completed and approved by 5/15/18.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	OCDSS will complete all safety assessments in the amount of time required.
Issue:	Failure to provide notice of report
Summary:	OCDSS did not document providing a Notice of Existence letter to the BF or the father of the SS.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)

Action:	OCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first 7 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.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	OCDSS did not make diligent attempts to contact the source of the report, despite having identifying information.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	OCDSS will contact, or make diligent efforts to contact the source of all SCR reports so as to verify the accuracy of the report and possibly gain additional information. Additionally, OCDSS will document contact or attempts at contact.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Documentation was unclear as to how information was obtained regarding family dynamics, DV, PD/AM, and supervision. The case record did not include independent interviews with the family regarding the reported concerns and overall safety and risk.
Legal Reference:	432.1 (o)
Action:	OCDSS will incorporate key safety related questions as they pertain to case circumstances. All adults living in the home, victim child(ren), and every other child in the household should be interviewed prior to closing the investigation. OCDSS will clearly document where information gathered was obtained.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/02/2015 **Time of Death:** Unknown

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

Was 911 or local emergency number called? Yes
Time of Call: Unknown
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: Unknown if they were 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	Deceased Child	Alleged Victim	Male	23 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	42 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Other Household 1	Father	No Role	Male	25 Year(s)

LDSS Response

OCDSS began the investigation on 05/07/18, after receiving an SCR report regarding the death of the SC. OCDSS quickly notified LE and within 24 hours of receiving the report, OCDSS assessed the safety of the SS and evaluated his environment, and noted no concerns. Additionally, OCDSS completed a CPS history check, an accurate 24-hour safety assessment and 24-hour fatality report were documented in a timely manner.

During the initial home visit, OCDSS interviewed the SM and learned that the death had been previously investigated in Mississippi, where the fatal incident occurred. The SM stated the fatality was investigated by state authorities at the time of the death; however, despite efforts, OCDSS was not able to obtain LE records. The MGM, who lived in the home both at the time of death and the time that this report was written, was made aware of the report, but did not provide any new information to OCDSS.

OCDSS and LE worked in conjunction to obtain information from several LE departments in Mississippi to no avail. LE in Mississippi could not locate a record of the death.

During the investigation, OCDSS contacted Ontario County's District Attorney requesting assistance in obtaining the ME report from Mississippi regarding the SC. The DA obtained the records and they were provided to OCDSS.

Although the SM stated that the BF was unknown, an obituary for the SC was obtained which contained the name of the BF. OCDSS contacted the BF of the SC by telephone on 07/02/18 to notify him of the report. The case record did not document confirmation of the BF being named by the SM, MGM or any collateral contacts. The BF had no knowledge of the SC until after he learned of the fatality and had no information provide to OCDSS. OCDSS did not make diligent attempts to contact the father of the SS regarding the report, despite having his name.

OCDSS contacted MFCS and received documentation of their investigation from 2015. The documentation stated that the SM was lying in her bed with both the SC and the SS when she fell asleep. SM stated that she was allowing the SS and the SC to sleep in bed with her as she was, "tired from getting up with him at night." When the SM awoke between 9:00AM and 9:30AM, she discovered she had rolled on top of the SC and found him unresponsive. The SM tried to move the SC and realized that he was not breathing. The SM immediately screamed for MGM and the MGM called 911 and performed CPR on the SC. EMS took over CPR efforts after they arrived at the SC's home. The SC was not transported to a medical facility for treatment and was declared deceased at the scene. Special Investigators from Mississippi observed the SC laying on a full-size mattress, with clothes on the bed.

Although the SM acknowledged receiving and understanding safe sleep guidance, and had a bassinet for the SC, she did

not follow safe sleep recommendations. OCDSS contacted the necessary collaterals and obtained the documents required to determine this report, including information that "some credible evidence" existed that the SM's actions placed the SC at risk of harm. MFCS indicated their report based on their state criteria. However, OCDSS appropriately unsubstantiated the allegations against the SM due to New York State having no jurisdiction to determine allegations regarding an incident that occurred in Mississippi.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Forensic Pathologist

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
Comments: The fatality was reviewed by the OCFS approved Ontario County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046557 - Deceased Child, Male, 23 Days	046940 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Unsubstantiated
046557 - Deceased Child, Male, 23 Days	046940 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
046942 - Sibling, Male, 2 Year(s)	046940 - Mother, Female, 20 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

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: Although SM declined new services that OCDSS offered, she continued to accept MH counseling.				

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:
OCDSS appropriately offered mental health counseling, trauma and family counseling and grief counseling to SM and

MGM, who declined on multiple occasions. During the investigation completed by MFCS, services of mental health counseling and grief counseling were offered. It was unknown if MGM utilized the resources; however, the SM has been involved in MH counseling since the death of the SC.

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? N/A
Explain:
The SS was 2yo at the time of the fatality, and services were not identified for him.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Immediately following the fatality, MFCS offered services including grief counseling which SM participated in. SM continued grief and mental health counseling provided through OCDSS. During the investigation, OCDSS offered services including family trauma intervention and bereavement counseling to SM and MGM, which were declined.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ 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)
02/08/2014	Sibling, Male, 1 Years	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	Yes

Other Child - Cousin, Male, 2 Years	Father, Male, 23 Years	Inadequate Guardianship	Substantiated
Other Child - Cousin, Male, 2 Years	Father, Male, 23 Years	Lacerations / Bruises / Welts	Substantiated

Report Summary:
OCDSS received an SCR report on 2/8/14 alleged that on 2/7/14, around 11:30PM, BF and the SM had an argument that became physical. The BF was punching and kicking the SM in the bedroom with the SS and a 2yo maternal cousin present. BF pushed the 2yo maternal cousin causing the child to fall backward and hit his head on the wall. The child sustained a large swollen bump on the back of his head. The mother of the 2yo maternal cousin, MA, had an unknown role.

Report Determination: Indicated | **Date of Determination:** 04/07/2014

Basis for Determination:
The investigation revealed that BF assaulted SM in the presence of SS and the 2yo maternal cousin. As a result, BF was arrested and charged with assault 2nd, was incarcerated, and an OP was granted for SM and the two children. OCDSS appropriately added an allegation of L/B/W after observing the 2yo maternal cousin with a bump on his forehead.

OCFS Review Results:
The biological fathers were not notified of the report in a timely manner and attempts were not made to discuss the report with them. Notice of Existence letters were not delivered to SM, SA or BF in a timely manner as well. It was documented that a review of CPS history was not completed until 19 days into the investigation.

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

Issue:
Review of CPS History
Summary:
There was no documentation of a CPS history check for the family until 19 days into the investigation.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, OCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, OCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day safety assessment was completed in Connections on 2/20/14. The safety assessment was due to be completed and approved by 2/15/14.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-day safety assessment in Connections.

Issue:
Failure to provide notice of report
Summary:
OCDSS did not provide the SM, BF or MA with Notice of Existence letters in a timely manner. The letters were generated in Connections on 2/21/14, and were to be mailed or hand delivered by 2/15/14. There was documentation of Notice of Existence letters being mailed to the father of the SS until 2/28/15.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
There is no documentation of the biological fathers being contacted or attempted to be contacted in regard to the report to gather additional information, although locating information was provided.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
OCDSS will make collateral and familial contacts, address all potential areas of concerns with all relevant parties, and adequately monitor any concerns.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Multiple progress notes were not entered contemporaneously during the investigation, and were documented 7 weeks after the event date.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
All progress notes will be entered as contemporaneously as possible to their event dates.

[redacted]

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

There is no CPS history more than 3 years prior to the fatality.

Known CPS History Outside of NYS

MFCS received a report on 07/02/15 and completed an investigation revolving around the SC's death. MFCS found no evidence of physical abuse to the SC, but substantiated allegations of physical neglect against the SM.

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: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**

07/31/2015	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	The Youth Court Reviewer adjourned the petition, and ordered no action be taken on 10/9/15.	

Criminal Charge: Assault **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	BF	Unknown	Unknown
Comments:	BF was arraigned on assault charges due to a DV incident. BF was arrested immediately after his arraignment for violating an Order of Protection. The outcome of that arrest was unknown.		

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: On or about 02/08/14, BF was arrested as a result of a DV incident and an Order of Protection was granted for SM, SS and a 2yo maternal cousin.	

Additional Local District Comments

"Report was unfounded due to a lack of jurisdiction to investigate an out-of-state fatality. If we do not have jurisdiction, the report should have been withdrawn and no fatality report completed. Therefore, there should be no required actions for OCDSS."

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