Child Fatality Report

Report Identification Number: RO-22-013

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

Issue Date: Sep 30, 2022

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 04/30/2022
Initial Date OCFS Notified: 04/30/2022

Presenting Information

An SCR report alleged on 4/20/22, prior to 3:00 AM, either the mother or grandmother co-slept with the 7-week-old subject child. When the adults woke up, the child was not breathing. The child was bleeding from her mouth and nose. The grandmother attempted to revive the child while the mother called 911. When EMS responded to the home, the child was unresponsive. CPR was performed for 40 minutes and the child was transported to the hospital and placed on a ventilator. On 4/30/22, the child was pronounced deceased as a result of co-sleeping. The child died during an open CPS case that was received on 4/20/22 regarding the fatal incident. The report alleged the mother found the child unresponsive and not breathing, with blood coming from her mouth and nose after they bedshared. A duplicate report was made on 4/21/22.

Executive Summary

This report concerns the death of the 2-month-old child that occurred on 4/30/22. The child died during an open investigation regarding the fatal incident which began on 4/20/22. The SCR reports alleged the mother found the child unresponsive and not breathing while they were bedsharing. The child was transported to the hospital and subsequently passed away. At the time of the child's death, she resided with her mother, maternal grandmother, the grandmother's partner, maternal uncle, and maternal cousins, aged 7 and 15 years. The cousins were assessed to be safe in the care of the grandmother, who had custody of the children after they were removed from the aunt's care.

Monroe County Department of Human Services (MCDHS) coordinated investigative efforts with law enforcement upon receipt of the SCR report regarding the fatal incident. There were no criminal charges pending at the time of case closure. An autopsy was performed; however, had not yet been received at the time this report was written.

The mother reported she placed the child in bed with her and fell asleep around 12:00 AM. When the mother awoke, she found the child face-down, unresponsive, and not breathing. The mother alerted the grandparents and the grandmother performed CPR while the mother called 911. EMS arrived at the home, took over resuscitation efforts, and transported the child to the hospital. The child was placed on a ventilator. The child was declared braindead, life-support was withdrawn, and the child was pronounced deceased on 4/30/22.

MCDHS made collateral contacts including medical personnel, first responders and relatives. The investigation did not reveal concerns for the care of the child or the cousins. The cousins did not provide additional information about the fatal incident. Although involved in the mother's life, the father had yet to meet the child due to his employment. The father was interviewed via phone and did not have information regarding the death.

MCDHS conducted home visits, met with family members and interviews were appropriate. Although the record reflected the maternal uncle resided in the home, there were no documented attempts to interview him. The uncle was documented to have a disability; however, it remained unclear if the disability prevented him from being interviewed.

MCDHS unsubstantiated the allegations of Inadequate Guardianship and DOA/Fatality against the grandmother noting that the grandmother's actions did not lead to the child's passing. The allegation of Inadequate Guardianship was substantiated against the mother as she placed the child in an unsafe sleeping environment. The mother's decision to bedshare with the child while the mother was "really tired" created an unsafe environment for the child. Additionally, there were pillows around the child. The allegations of DOA/Fatality and Internal Injuries were unsubstantiated against

the mother. MCDHS noted there was not enough evidence to support the allegations. MCDHS requested a copy of the final autopsy report from the medical examiner upon its completion and should the autopsy reveal any evidence of abuse, the fatality would be reported to the SCR.

PIP Requirement
MCDHS will submit a PIP to the Rochester Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the MCDHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDHS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **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

Explain:
The decision to close the case was appropriate.

Was the decision to close the case appropriate? Yes

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:
Casework activity was not commensurate with case circumstances as a 30-day Safety Assessment was not completed. The RAP was completed inaccurately. Written Notice of Existence and written Notice of Indication letters were not provided to all adults, including parents of children listed on the reports.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The record did not reflect a 30-day Safety Assessment was completed.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	MCDHS must complete a Safety Assessment at 30 days for reports of a child fatality, unless there are no surviving siblings or children in the household. This is in addition to the 24-hour assessment, the initial 7-day assessment and the conclusion Safety Assessment that must be completed within 7 days prior to closing the case.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP was completed inaccurately as it reflected the child died as a result of abuse or maltreatment by a caretaker; however, the allegation of DOA/Fatality was unsubstantiated.
Legal Reference:	18 NYCRR 432.2(d)
Action:	MCDHS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.
Issue:	Failure to provide notice of report
Summary:	The record did not reflect the father of the 15-year-old cousin was provided with written notice of the SCR reports. The uncle was not provided with written notice regarding the SCR report involving the death.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	MCDHS 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:	Failure to Provide Notice of Indication
Summary:	The record did not reflect the uncle was provided with written notice that the report regarding the fatal incident was indicated. The father of the 15-year-old cousin was not provided with a Notice of Indication letter regarding either SCR report.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	Within 60 days, whether a report assigned to the investigative track is "indicated" or "unfounded" and, if "indicated," delivers or mails to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within 7 days of the determination, in such form as required by OCFS.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/30/2022 **Time of Death:** 05:42 PM

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: 02:08 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 1 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	Aunt/Uncle	No Role	Male	31 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	52 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	50 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Other Child - Maternal Cousin	No Role	Male	15 Year(s)
Deceased Child's Household	Other Child - Maternal Cousin	No Role	Female	7 Year(s)
Other Household 1	Father	No Role	Male	27 Year(s)

LDSS Response

On 4/20/22, MCDHS received a report from the SCR regarding the fatal incident and began their investigation. MCDHS contacted law enforcement, the source of the report, documented a CPS history check and contacted family members. The cousins were assessed to be safe in the care of the grandmother.

On 4/20/22, MCDHS met with law enforcement officers who reported the mother co-slept with the child. After receiving a 911 call, law enforcement responded to the home and observed the grandmother performing CPR on the child. Law enforcement officers took over resuscitation efforts until EMS responded and transported the child to the hospital. Blood was observed on the child's face. Hospital staff informed law enforcement that the child's outlook was grim. The child regained a pulse but was unable to breathe independently.

MCDHS and law enforcement interviewed the grandmother on 4/20/22. The grandmother reported she was watching

television in her bedroom when the mother said, “the baby, the baby.” The grandmother observed blood coming from the child’s nose. The grandmother stated she panicked and shook the child in an attempt to wake the child prior to calling 911. The grandmother reenacted shaking the child and MCDHS documented it was “not forceful or aggressive in nature”; however, the record did not reflect this was further explored with family or medical staff to determine possible harm it may have caused to the child.

The mother reported on 4/19/22, between 8:00 PM- 9:00 PM, she fed the child and they laid in bed together. She placed the child on her back on top of a pillow and the child was swaddled in a HALO Sleepsack. The mother reported that she fell asleep around 12:00 AM and woke up around 1:00 AM and the child was face-down and unresponsive. The mother reported having a bassinet for the child to sleep in; however, she did not use it as she liked to be with the child. The mother reported she liked to lay her head against the child’s head while the child fell asleep to be sure the child did not move. The record reflected safe sleep recommendations were stressed with the mother.

A home visit was made on 4/20/22. The grandmother’s partner said he was asleep when the mother came into the room with the unresponsive child. He tried to call 911, but his phone was not working. The bed where the mother and child were sleeping was observed. On the bed were various blankets, pillows, a u-shaped pillow, and other miscellaneous items including headphones and wrappers. The 7-year-old cousin was observed; however, would not engage in a conversation despite attempts. The 15-year-old cousin said he was unaware of what happened to the child and stated that no one was ever rough with the child and that she was well cared for. The cousin noted the mother had previously bedshared with the child.

MCDHS obtained the 911 call as well as EMS records that note the mother was bedsharing with the child. The records detailed the mother finding the child unresponsive with blood coming from her nose. The 911 dispatcher instructed the grandmother on how to perform CPR until EMS responded.

The hospital provided information that the child was critically ill and was at risk of organ failure due to respiratory failure, shock and/or cardiac arrest. After multiple brain tests, the child was declared braindead. On 4/30/22, life-support was withdrawn, and the child passed away. MCDHS initiated the SCR report regarding the death timely and gathered appropriate information to reassess the safety of the cousins. Additionally, the medical examiner and district attorney’s offices were made aware of the death, and the source of the report was contacted.

The family was offered bereavement services in response to the death. The mother and grandparents accepted the services for themselves and the cousins. The father stated he would rely on his family for support, and he was located outside of Monroe County. The investigations were closed timely on 6/14/22.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061382 - Deceased Child, Female, 2 Mons	061424 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
061382 - Deceased Child, Female, 2 Mons	061424 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
061382 - Deceased Child, Female, 2 Mons	061424 - Mother, Female, 29 Year(s)	Internal Injuries	Unsubstantiated
061382 - Deceased Child, Female, 2 Mons	061421 - Grandparent, Female, 52 Year(s)	DOA / Fatality	Unsubstantiated
061382 - Deceased Child, Female, 2 Mons	061421 - Grandparent, Female, 52 Year(s)	Inadequate Guardianship	Unsubstantiated
061382 - Deceased Child, Female, 2 Mons	061421 - Grandparent, Female, 52 Year(s)	Internal Injuries	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 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:
Despite appropriate attempts, the 7-year-old cousin was not interviewed. The family accepted services in response to the death including bereavement services. The RAP did not accurately reflect case circumstances.

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 surviving children did not need to be removed.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

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:
The cousins were referred to bereavement services in response to the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother and grandparents were offered bereavement services in response to the fatality. The father utilized family members to cope with his grief.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	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?	Yes
Was the child acutely ill during the two weeks before death?	Yes

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/16/2021	Other Child - Maternal Cousin , Male, 14 Years	Aunt/Uncle, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report alleged a maternal aunt (MA2) was unable to control the behaviors of the 14yo maternal cousin (MC). MA2 was the aunt of the MC. On 1/15/21, the MC was out of control and used a knife to stab a couch, pillows and MA2's purse. He made threatening statements to MA2. LE was called and the MC was taken to a hospital for a psychiatric evaluation. The MC was stabilized and cleared to leave the hospital. MA2 refused to take the MC home or assist in planning for the MC.

Report Determination: Unfounded **Date of Determination:** 03/10/2021

Basis for Determination:
The allegations were unsubstantiated. The investigation revealed MA2 was not a person legally responsible for the MC's care. MA2 intended to assist the MC, but within 3 days he was violent and out of control. At the time the investigation was determined, the MC was missing from Foster Care and a missing person report was filed by MCDHS.

OCFS Review Results:
The investigation was initiated timely. Interviews with the children, SM and MC were appropriate. Collateral contacts were made. Attempts were made to interview the father of one of the children, but not the father of the MC.

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

Issue:
Failure to provide notice of report

Summary:
Although written Notice of Existence letters were provided to all adults, they were provided untimely on 1/28/21.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:

MCDHS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/14/2020	Aunt/Uncle, Female, 9 Years	Aunt/Uncle, Female, 31 Years	Educational Neglect	Substantiated	Yes
	Aunt/Uncle, Female, 9 Years	Aunt/Uncle, Female, 31 Years	Excessive Corporal Punishment	Substantiated	
	Aunt/Uncle, Female, 9 Years	Aunt/Uncle, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Aunt/Uncle, Female, 9 Years	Aunt/Uncle, Female, 31 Years	Lacerations / Bruises / Welts	Substantiated	
	Aunt/Uncle, Female, 9 Years	Aunt/Uncle, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Other Child - Maternal Cousin , Female, 4 Years	Aunt/Uncle, Female, 31 Years	Educational Neglect	Substantiated	
	Other Child - Maternal Cousin , Female, 4 Years	Aunt/Uncle, Female, 31 Years	Excessive Corporal Punishment	Substantiated	
	Other Child - Maternal Cousin , Female, 4 Years	Aunt/Uncle, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Other Child - Maternal Cousin , Female, 4 Years	Aunt/Uncle, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Other Child - Maternal Cousin , Male, 7 Years	Aunt/Uncle, Female, 31 Years	Educational Neglect	Substantiated	
	Other Child - Maternal Cousin , Male, 7 Years	Aunt/Uncle, Female, 31 Years	Excessive Corporal Punishment	Substantiated	
	Other Child - Maternal Cousin , Male, 7 Years	Aunt/Uncle, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Other Child - Maternal Cousin , Male, 7 Years	Aunt/Uncle, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Other Child - Maternal Cousin , Male, 13 Years	Aunt/Uncle, Female, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Other Child - Maternal Cousin , Male, 13 Years	Aunt/Uncle, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Other Child - Maternal Cousin , Male, 13 Years	Other Adult - Maternal Aunt's Partner, Female, 23 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Other Child - Maternal Cousin , Male, 13 Years	Other Adult - Maternal Aunt's Partner, Female, 23 Years	Inadequate Guardianship	Substantiated	
	Other Child - Maternal Cousin , Male, 13 Years	Aunt/Uncle, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report alleged a maternal aunt (MA) had mental health issues and alcoholism. She fought with the 13-year-old maternal cousin (MC). On 2/13/20, the MA kicked the MC out of the home and did not have a plan for the MC. LE intervened and the MC was allowed back into the home. On 2/14/20, the MGF took the MC to school as the MA refused

to do so. The MA again kicked the MC out of the home and advised her partner not to take the MC in. When the MC went to that home, he was not allowed in. Neither the MA nor her partner made an adequate plan for the MC.

Report Determination: Indicated | **Date of Determination:** 03/24/2020

Basis for Determination:
The investigation revealed the MA and her partner were involved in physical DV while the MA was intoxicated. The DV included the partner being stabbed. The investigation also revealed the CHN were physically disciplined with objects, had marks and bruises on them and were fearful of the MA. The MA would not send the CHN to school so the marks and bruises could not be observed. Marijuana was observed in the home and the CHN did not have adequate clothing. The 5 and 13yo MCs were placed in the care of the MGM and the MA's other CHN (also cousins) were placed in Foster Care.

OCFS Review Results:
The investigation was initiated timely and home visits were made. The MA and children were interviewed; however, the fathers nor the MA's partner were documented to have been interviewed. The RAP was completed accurately. The Safety Assessments were completed timely and accurately. Written Notice of the SCR report was not provided to all adults. Progress notes were entered contemporaneously. An allegation that was added to the investigation was inappropriately substantiated.

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

Issue:
Appropriateness of allegation determination
Summary:
Although the children reported the MA was not sending them to school regularly, the record did not reflect that the children were negatively impacted by their absences. Educational Neglect was substantiated regarding the 4-year-old cousin, who was not legally required to attend school due to her age.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
MCDHS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Rochester Regional Office if further guidance is needed.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
The record did not reflect attempts to contact the fathers of the children or to interview the MA's partner, who was an alleged subject of the report.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
MCDHS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Failure to provide notice of report
Summary:
Although the MA was provided with written notice of the SCR report, the record did not reflect the MA's partner, nor the fathers of the children were provided with written notice.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:

MCDHS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/22/2019	Other Child - Maternal Cousin , Male, 13 Years	Aunt/Uncle, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Maternal Cousin , Male, 13 Years	Grandparent, Female, 49 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report alleged on 12/22/19, the MA became upset with the MC and kicked him out of the house, refusing to make an alternate plan for him. On 1/20/20, a subsequent report was made alleging the MGM kicked the MC out of the home. On 1/19/20, the MC was arrested due to a "mental health breakdown" and was taken for an evaluation. The MC had a knife and was stabbing a box and threatening to kill the MA. LE was called and the MC was transported to a medical facility where he was cleared for discharge; however, the MGM and MA refused to plan for the MC.

Report Determination: Indicated **Date of Determination:** 01/30/2020

Basis for Determination:
The allegations against the MGM were substantiated as she had custody of the MC and was uncooperative with the hospital, CPS and the Center for Youth. She failed to plan for the MC, despite having custody. The MA was unsubstantiated as she was willing to care for the MC.

OCFS Review Results:
The Safety Assessments were completed timely and accurately. A CPS history check was completed timely. The record did not reflect attempts to contact the sources of the reports. The fathers of the children were not attempted to be interviewed regarding the SCR report. Progress notes were entered timely. Notice of Existence and Notice of Indication letters were provided to the adults.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The record did not reflect attempts to contact the sources of the reports or to contact the fathers of the children.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
MCDHS will contact, or make diligent efforts to contact, the source of all SCR reports so as to verify adequacy of report and possibly glean additional information. MCDHS will make attempts to contact absent parents as they may have collateral information regarding the safety and risk of the children named in the SCR report(s).

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

1/04/07- 02/05/07 The MA Sub for IG and IF/C/S of the 15yo MC.

9/11/13- 10/15/13 FAR The MA had allegations of IG, BURN, PD/AM, IF/C/S, and XCP regarding 3 other CHN.

7/3/14- 9/12/14 The MA was Sub for IG and PD/AM regarding the 7yo MC.

12/5/16- 12/5/17 The MGM was UnSub for XCP, IG and L/B/W of another child.

3/28/18- 5/17/18 The MGM and her partner were UnSub for IG, L/B/W and PD/AM of 5 other children.

7/2/19-10/1/19 The MGM was UnSub for XOTH regarding 3 other children.

Known CPS History Outside of NYS

There is no known history outside of New York.

Preventive Services History

Between October 2005 and February 2020, the family had 6 Services cases. The MGM requested assistance as her child was shot and required intensive medical care. MCDHS connected the MGM with community resources until she was able to care for her child. The MGM received services as her children had behavioral issues she could not control. Her children were deemed Persons in Need of Supervision and there was a Juvenile Delinquent arrest for theft. The MGM utilized casework counseling as well as community resources for housing, MH counseling and financial assistance. The MGM's children were in the care and custody of OCFS due to their behaviors. The MGM did not want further intervention from MCDHS. In 2017, MA2's children, who were in the care of the MGM, were placed in Foster Care on a voluntary basis as the MGM had a medical condition that affected her ability to care for them. A Neglect Petition was not filed as it was a voluntary basis and the MGM believed she would be able to care for the children within less than 3 weeks and the children were returned to her within that timeframe. In 2020, a Preventive Services Case was opened as the 13yo MC had behavioral concerns and struggled with his MH. The family did not make contact with MCDHS, and the Case was closed.

Foster Care Placement History

On 7/10/14, MCDHS filed an Article 10 Neglect Petition against the MA regarding the 7-year-old cousin. The cousin was removed from the MA's care and custody as a result of her ongoing drug misuse. The cousin was placed with the grandmother, who obtained custody of her on 11/12/14. The MA was incarcerated for unrelated charges and when she was released, the cousins began residing with her again. On 3/3/20, the 7 and 15-year-old cousins were removed from the aunt's care, and on 3/5/2020 they were discharged to the grandmother. On 7/13/20, the 15-year-old cousin was placed in Foster Care as a result of his unruly behaviors. The cousin was discharged to the grandmother on 1/7/22.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒ Family Court ☐ Criminal Court ☐ Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/03/2020	Other, Specify	Direct Custody to/or Continued with Relative (Article 10)
Respondent:	051301 Other	
Comments:	On 3/3/2020, the maternal cousins were removed from the care of the maternal aunt. The grandmother had custody of the 7 and 15-year-old cousins and they returned to her home. The other cousins were placed in Foster Care.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/08/2020	There was not a fact finding	Custody Transferred to Relative or Non-Relative Foster Care
Respondent:	051301 Other	
Comments:	The 15-year-old cousin was placed in Foster Care via an Article 10 Neglect Petition. He was placed in a residential facility until 12/14/20 when he was placed on a trial discharge to the grandmother. On 1/19/21, he returned from the trial discharged and on 1/7/22, the cousin was discharged to the grandmother.	

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