Child Fatality Report

Report Identification Number: RO-22-031

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

Issue Date: Mar 21, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 8 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 10/04/2022
Initial Date OCFS Notified: 10/04/2022

Presenting Information

Monroe County Department of Human Services (MCDHS) received a report alleging that on 10/4/22, while in the care of the mother and father, the 8-month-old subject child passed away. At around 8:00 AM, the father fed the child and placed her in a car seat to sleep. Sometime before 10:30 AM, the father heard the 8-month-old twin sibling crying and went to check on her. While checking on the twin, the father noticed the subject child was unresponsive and had foam coming from her mouth. The father began CPR on the child and called 911. First responders arrived and transported the child to the hospital. Life-saving measures were unsuccessful and the child was pronounced dead at 11:08 AM. The child was otherwise healthy and the parents had no explanation for her death.

Executive Summary

On 10/4/22, MCDHS received a report regarding the death of the 8-month-old female subject child who died on the same date. At the time of the child's death, she resided at home with her mother, father, and siblings ages 11, 6, 3-year-old twins, and an 8-month-old twin. The family was known to MCDHS as there were multiple historical investigations.

The investigation revealed the two sets of twins were at home with the parents on the morning of 10/4/22, while the 11 and 6-year-old siblings were at school. It was learned the parents left the children in the apartment while they went outside to smoke marijuana for approximately one hour. All four children that were home at the time of the death were alleged to be asleep in one bedroom together. The 3-year-old twins were sleeping in separate cribs, the 8-month-old twin was asleep in a portable crib, and the subject child was sleeping in a car seat. The father went into the home to check on the children about an hour and a half after they were put down for a nap. At that time, the father found the subject child to be stiff and not breathing. The father attempted CPR while the mother called 911. First responders arrived at the home and began resuscitative efforts. The child was transported to the hospital where she was pronounced deceased at 11:08 AM.

MCDHS coordinated investigative efforts with law enforcement upon receipt of the SCR report. The record did not reflect whether an autopsy was conducted or the results of a postmortem exam. The record did not reflect whether the law enforcement investigation remained open.

MCDHS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, community-based service providers, and relatives. MCDHS provided fatality-related services to the family upon receipt of the fatality report. Preventive Services remained ongoing following the determination of the investigation and the mother was engaged in community-based services, trauma-based therapy, mental health counseling, and homemaking services.

PIP Requirement
MCDHS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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?** No

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:
There were instances in the case record of insufficient documentation and missed opportunities to gather information from collateral sources, including the medical examiner and law enforcement. MCDHS inaccurately determined the allegation of DOA/Fatality against both parents regarding the subject child.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	Conversations with medical personnel were lacking key safety-related questions. MCDHS did not discuss with medical personnel how the aggravating factors may have contributed to the child's death and made a determination of the allegations lacking vital information directly related to the cause of death.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	MCDHS will make an adequate assessment of the nature, extent, and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/04/2022 **Time of Death:** 11:08 AM

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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ 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	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	8 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)

LDSS Response

On 10/4/2022, MCDHS received the SCR fatality report regarding the subject child. Upon receipt of the fatality report, MCDHS initiated their investigation within 24 hours and coordinated efforts with their MDT. MCDHS reviewed the family's history, which revealed significant CPS involvement.

MCDHS interviewed the parents at the home alongside law enforcement. It was noted in the case record that the mother was under the influence at the time of the initial interview. The mother and father reported they put the four children down for a nap around 9:00 AM on 10/4/22. The parents then went into the hallway of their apartment complex around 9:30 AM to smoke marijuana. They both reported leaving the door cracked so they could hear the children if they woke. They reported they were in the hallway for approximately an hour when the father went into the apartment to check on the

children. It was at that time the father found the subject child stiff and not breathing. He called for the mother and attempted CPR. Both parents called 911 and the father reported he was unable to administer CPR as the subject child's mouth was "clenched shut." The mother reported it was common practice for the 8-month-old twins to sleep in their car seats and she and the father regularly propped bottles for the children as they were not able to properly hold the bottles themselves yet. The mother reported she and the father share approximately five blunts each day and were typically "high" throughout the day every day. MCDHS made an immediate safety plan for the siblings to stay with alternate caregivers due to the parents' substance use and inability to demonstrate developmentally appropriate expectations for the children.

MCDHS assessed the children with their alternate caregivers and determined they were safe. The 3-year-old twin siblings were assessed with their paternal grandmother, while the three other siblings went to the maternal grandmother's home. Safe sleep was addressed with the maternal grandmother and there was an observed suitable safe sleeping arrangement for the 8-month-old twin sibling. The 11 and 6-year-old siblings were interviewed and denied knowledge of the parents' substance use but reported the mother was often sad and crying. Both older siblings reported the younger siblings spent most of their day either in their portable cribs or strapped into their car seats.

MCDHS developed a formal safety plan with the parents prior to the siblings' return home. The plan detailed that the parents would not use substances while caring for the children, would utilize a safe sleep environment, and would provide appropriate supervision for all the siblings. A preventive service case was opened to monitor the plan was followed.

MCDHS met with their legal department, though the record did not reflect the details of the consultation. The family continued working with preventive services on a voluntary basis at the time of this writing. MCDHS determined there was credible evidence to substantiate the allegation of Inadequate Guardianship against the mother and father regarding the subject child. MCDHS added and substantiated the allegations of Lack of Supervision, Inadequate Guardianship, and Parent's Drug/Alcohol Misuse against the parents regarding the 8-month-old sibling and 3-year-old twin siblings. MCDHS unsubstantiated the allegation of DOA/Fatality for the subject child despite the unsafe sleep environment, citing in the determination narrative that the final autopsy had not yet been received. MCDHS provided ongoing services and support following the closing of the investigation.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: MCDHS adhered to previously approved protocols for joint investigations by coordinating efforts with law enforcement and notifying the DA's office of the death.

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
062738 - Deceased Child, Female, 8 Mons	062739 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated

062738 - Deceased Child, Female, 8 Mons	062740 - Father, Male, 32 Year(s)	Lack of Supervision	Substantiated
062738 - Deceased Child, Female, 8 Mons	062739 - Mother, Female, 36 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
062738 - Deceased Child, Female, 8 Mons	062739 - Mother, Female, 36 Year(s)	Lack of Supervision	Substantiated
062738 - Deceased Child, Female, 8 Mons	062740 - Father, Male, 32 Year(s)	DOA / Fatality	Unsubstantiated
062738 - Deceased Child, Female, 8 Mons	062740 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
062738 - Deceased Child, Female, 8 Mons	062740 - Father, Male, 32 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
062738 - Deceased Child, Female, 8 Mons	062739 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
062741 - Sibling, Female, 8 Month(s)	062739 - Mother, Female, 36 Year(s)	Lack of Supervision	Substantiated
062741 - Sibling, Female, 8 Month(s)	062740 - Father, Male, 32 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
062741 - Sibling, Female, 8 Month(s)	062740 - Father, Male, 32 Year(s)	Lack of Supervision	Substantiated
062741 - Sibling, Female, 8 Month(s)	062739 - Mother, Female, 36 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
062742 - Sibling, Female, 3 Year(s)	062739 - Mother, Female, 36 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
062742 - Sibling, Female, 3 Year(s)	062739 - Mother, Female, 36 Year(s)	Lack of Supervision	Substantiated
062742 - Sibling, Female, 3 Year(s)	062740 - Father, Male, 32 Year(s)	Lack of Supervision	Substantiated
062742 - Sibling, Female, 3 Year(s)	062740 - Father, Male, 32 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
062743 - Sibling, Female, 3 Year(s)	062740 - Father, Male, 32 Year(s)	Lack of Supervision	Substantiated
062743 - Sibling, Female, 3 Year(s)	062739 - Mother, Female, 36 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
062743 - Sibling, Female, 3 Year(s)	062739 - Mother, Female, 36 Year(s)	Lack of Supervision	Substantiated
062743 - Sibling, Female, 3 Year(s)	062740 - Father, Male, 32 Year(s)	Parents Drug / Alcohol Misuse	Substantiated

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?	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☒	☐	☐
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:
Notes were entered contemporaneously with their event dates and alleged subjects were interviewed. The record did not reflect that the medical examiner was contacted, nor whether an autopsy was conducted.

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: MCDHS provided preventive services to the family for additional support following the death.				

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐
Explain as necessary: There was no removal regarding the surviving siblings. A safety plan was put in place for the children to stay with their grandmother immediately following the death, but the children returned home upon MCDHS deeming it safe to do so.				

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Preventive Services

Additional information, if necessary:
MCDHS referred the family to preventive services and provided them with community-based referrals for bereavement and mental health counseling. The family was receptive to trauma-informed therapy for the older siblings and the twin sibling was referred to early intervention.

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:
MCDHS provided preventive services to the family following the death. Referrals for community based bereavement and mental health counseling were provided.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Preventive services were provided to the parents following the death.

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? 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
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ Used prescription drugs
☐ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ With none of the issues listed noted in case record

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)
09/28/2020	Sibling, Male, 9 Years	Mother, Female, 34 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Male, 9 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 15 Months	Mother, Female, 34 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Female, 15 Months	Mother, Female, 34 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
MCDHS received a report alleging the then 9-year-old sibling had been absent 11 consecutive days for the 2020-2021 school year by 9/28/20. The sibling had fallen behind as a result and had a history of excessive absences having a negative impact on his educational success. An Individualized Education Plan (IEP) was put in place for the school year to improve the child's academics; however, the absences continued. A subsequent report was received on 10/6/20, alleging the mother failed to provide medical treatment for the then year old twins. The twins needed medical monitoring and appointments with specialists; however, the mother had not followed through with appointments.

Report Determination: Unfounded | **Date of Determination:** 11/10/2020

Basis for Determination:
MCDHS determined there was no credible evidence to substantiate the allegations. The mother attempted to have the then 9-year-old sibling engage in remote learning but found she could not create an environment at home conducive to remote school. The sibling engaged in school following receipt of the SCR report and began attending in person regularly. The mother reported she missed several appointments for the twin siblings due to the pandemic, but appointments were confirmed and attended during the investigation.

OCFS Review Results:
MCDHS completed safety assessments adequately and within the required timeframes. All appropriate casework contacts were notified in writing of the report. Concerns regarding the twin siblings' medical treatment and appointments were not fully explored. Allegations regarding LMC were subsequently received and medical personnel confirmed the twins had medical complications that were not followed up on. MCDHS spoke with the mother, who confirmed the children were seen by their primary care, though there was no follow-up with the physician to confirm appointments were made and MCDHS did not receive a prescribed plan for their treatment.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:

The case was pre-determined to the assessment of the allegations. MCDHS did not gather relevant collateral information to determine whether the twin siblings had attended their medical appointments nor did MCDHS obtain the prescribed medical plans for the siblings, leaving it unclear as to the validation of what was alleged.

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(c)

Action:

MCDHS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.

[redacted]

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

From 2012 to 2016, the mother was named as a subject in four unfounded reports with common allegations of IG, LS, and PD/AM.

The mother was the subject of four indicated reports in 2005, 2008, and 2011 with the common allegation of IG.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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