Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-17-025

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

Issue Date: Feb 15, 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: 1 year(s)
Jurisdiction: Montgomery
Gender: Male
Date of Death: 12/09/2014
Initial Date OCFS Notified: 08/17/2017

Presenting Information

On 8/17/17, the Montgomery County Department of Social Services (MCDSS) received an SCR report regarding the death of the 1 yo male SC. The report alleged in the past, the SM left liquid nicotine out and accessible to the SC. On an unknown date, the SM was not properly supervising the SC and as a result, the SC ingested the liquid nicotine and died shortly after. Further details of the SC's death were unknown. The SM gave birth to the newborn SS on 8/16/17. The SM had another child that was removed from her care due to neglect and was not in the SM's care. There was concern for the SM's ability to safely care for the newborn SS due to the SM's history of maltreating children.

Executive Summary

On 8/17/17 MCDSS received an SCR report regarding the death of the 1 yo SC as well as additional concerns for the newborn SS. Through interviews conducted by MCDSS it was learned that the SC passed away on 12/9/14 from an accidental ingestion of liquid nicotine. SM's wife (Stepmother) was watching the SC while SM was Christmas shopping. Stepmother brought the SC to Stepmother's sister home and Stepmother's sister was not home at the time. Stepmother and her sister's male partner (Other Adult, OA) were looking for the remote control for the television and a DVD for the SC to watch when the SC picked up an uncapped bottle of liquid nicotine that had been left out on a table in the dining room and drank some of the nicotine. Stepmother and OA saw that the SC was holding the bottle and was pale with his eyes rolling back. Stepmother called 911 and the OA brought the SC to a neighbor's home for assistance. The neighbor performed CPR until the ambulance arrived. The SC was transported via ambulance to Little Falls Hospital. The SC was pronounced deceased by the hospital physician at 5:53 PM.

An autopsy was performed on 12/11/14 at Albany Medical Center by a Forensic Pathologist. The cause of death was determined to be cardiac arrhythmia due to acute nicotine ingestion/intoxication (liquid form) and manner of death was accident.

LE investigated at the time of the incident and per LE records, based on evidence gathered at the time of the incident, statements from the OA, Stepmother and Stepmother's sister, the physical inspection of the home by LE, and the Coroner's report, the case was closed as an accident.

Since the SC's death, SM had 2 children, with 2 different male partners. There have been multiple SCR reports received by MCDSS regarding each of the SS. An Article 10 Neglect Petition filed due to unsafe home conditions and concerns for ongoing DV between SM and her partner resulted in Foster Care placement of the 1 yo SS on 1/26/17 and again on 6/2/17 when a court order was violated. There was an OP in place at the time against the 1 yo SS's BF that required he stay away from SM and the 1 yo SS. Due to continued and ongoing concerns about DV, the newborn SS was placed in Foster Care on 8/25/17 and an Article 10 Neglect Petition was filed in Family Court against the SM and her partner (BF of the newborn SS). The petitions were pending in Family Court at the time this report was written.

MCDSS assessed the safety of the 2 SS and interviewed SM, SM's partner, Stepmother, Stepmother's sister and the OA upon receipt of the fatality investigation. The BF of the SC was not interviewed and may have had pertinent information regarding the investigation of the SC's death. MCDSS contacted multiple collaterals, including the neighbor, LE, EMS, the DA's office and the Coroner's office to gather information about the SC's death. All evidence gathered supported LE's finding that the incident was accidental. The case remained open for investigation and both SS remained in Foster Care at the time this report was written.

PIP Requirement

OCFS review of the fatality investigation and CPS history resulted in citations for Adequacy of face-to-face contacts with the child and/or child's parents or guardian. MCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) the MCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, MCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
The case remained open at the time this report was written.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
The case remained open at the time this report was written.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or childs parents or guardians
Summary:	BF was added to the report as a parent and notified about the investigation. Although he visited the SC, there was no effort to interview him.

Legal Reference:	432.1 (o)
Action:	MCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/09/2014 **Time of Death:** 05:53 PM

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

County where fatality incident occurred: Montgomery
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? Yes
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Not 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	1 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Day(s)
Deceased Child's Household	Stepmother	No Role	Female	41 Year(s)
Other Household 1	Father	No Role	Male	25 Year(s)
Other Household 2	Sibling	No Role	Male	1 Year(s)
Other Household 3	Mother's Partner	Alleged Perpetrator	Male	37 Year(s)
Other Household 4	Other Adult - 1 yo SS's BF	No Role	Male	35 Year(s)

Other Household 5	Other Adult - Stepmother's Sister's Partner	No Role	Male	37 Year(s)

LDSS Response

Upon receipt of the report on 8/17/17, MCDSS contacted the hospital social worker and learned the SM had given birth to the newborn SS and there were concerns for the SM's ability to care for the SS based on the 1 yo SS being in Foster Care, the prior death of the SC and the SM's lack of bonding with the newborn SS. MCDSS contacted LE, the DA's office and the Coroner's office to gather more information about the SC's death. It was learned the SC passed away on 12/9/14. MCDSS conducted a hospital visit and interviewed the SM and observed the newborn SS. The newborn SS was assessed to be safe at that time. It was learned the SM was not present for the SC's death and the Stepmother was caring for the SC at the time. The Stepmother contacted her after the incident occurred and told her what happened. The SM stated there were no criminal charges or SCR report that resulted from the incident. The SM said the Stepmother was helping the OA unpack the Stepmother's sister's items the day prior and found the broken bottle of liquid nicotine and she asked the OA to throw it away.

The Stepmother was interviewed and stated the death of the SC was an accident. She was watching the SC and brought the SC to her sister's home, who was in the process of moving into the home. The Stepmother and the OA were searching for the remote control for the television and a DVD for the SC to watch. She turned around and saw the SC had a bottle of liquid nicotine to his mouth, he was turning white and his eyes were rolling into the back of his head. She asked the OA to throw the bottle away the day prior and she thought he did. She tried to make the SC throw up but he wouldn't. The OA took the SC across the street to a neighbor in LE who was trained in CPR and Stepmother called 911. She contacted the SM while she was riding in the ambulance with the SC and LE interviewed her sister, who had returned home, and the OA.

The Stepmother's sister and OA were interviewed. The OA recalled that he took the SC to the neighbor's home for assistance. The Stepmother's sister stated she wasn't home at the time of the incident and she didn't know the SC was coming to her home that day. She was moving into the home and thought she had time to unpack before the SC came to her home. She arrived at the home as the ambulance was leaving with the SC. There was no information in the record to indicate that the Stepmother or OA were under the influence of drugs or alcohol at the time of the incident.

While investigating the current allegations regarding the newborn SS, concerns arose for ongoing DV between the SM and her partner in the presence of the newborn SS. MCDSS obtained an OP that barred the SM's partner from contact with the newborn SS. The OP was violated so the newborn SS was appropriately placed in Foster Care and an Article 10 Neglect Petition was filed against SM and her partner.

Both SS's safety was assessed in their foster boarding home. BF and the BF of the 1 yo SS were not spoken to, although they were provided with notice of existence of the SCR report. BF visited with the SC and he may have had information pertinent to the investigation of the SC's death. MCDSS contacted other necessary collaterals and gathered sufficient documentation to determine that the SC's death was due to accidental liquid nicotine ingestion. MCDSS appropriately added the allegation of IG against the SM's partner regarding the newborn SS. The case remained open for investigation at the time this report was written. During the open Foster Care case, the SM and her partner were already engaged in MH counseling and the SM was referred for parenting skills training and DV services and her partner was referred to substance abuse services due to alcohol abuse concerns. There were no additional service needs identified because of the SC's death.

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: Other physician

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? No

Comments: LE had already conducted an investigation into the fatality of the SC in 2014 when the incident occurred. MCDSS reviewed the records from the previous LE investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No

Comments: Montgomery County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
043321 - Deceased Child, Male, 1 Yrs	043381 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
043321 - Deceased Child, Male, 1 Yrs	043381 - Mother, Female, 26 Year(s)	Poisoning / Noxious Substances	Pending
043321 - Deceased Child, Male, 1 Yrs	043381 - Mother, Female, 26 Year(s)	DOA / Fatality	Pending
043321 - Deceased Child, Male, 1 Yrs	043381 - Mother, Female, 26 Year(s)	Lack of Supervision	Pending
043385 - Sibling, Male, 1 Day(s)	043381 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
043385 - Sibling, Male, 1 Day(s)	043402 - Mother's Partner, Male, 37 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

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

Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
LE conducted an investigation after the incident in 2014. A death scene investigation was conducted by LE at that time. The SF was not interviewed about the SC's death.

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	☒	☐	☐	☐

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The newborn SS was removed and placed in foster care on 8/25/17 and an Article 10 Neglect Petition was filed due to concerns for ongoing DV in the presence of the SS and the OP that barred SM's partner from the SS was violated. The 1 yo SS was already in Foster Care at that time. Both SS were placed in Foster Care for reasons unrelated to the fatality.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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:
Bereavement counseling was not offered. SM and her partner were engaged in MH counseling at the time the fatality investigation was received. MCDSS had also referred SM to parenting skills training and DV services and referred SM's partner to substance abuse services. The MA stayed with SM temporarily as a safety plan prior to the newborn SS being placed in Foster Care.

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:
There were no siblings at the time of the SC's death. At the time of the fatality investigation the 1 yo SS was already in Foster Care. The newborn SS was removed and placed in Foster Care during the investigation for reasons unrelated to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There was no SCR report of the fatality at the time of death. At the time of the current fatality investigation, the SM was already receiving MH counseling services and Foster Care services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/15/2014	Deceased Child, Male, 11 Months	Father, Male, 22 Years	Inadequate Food / Clothing / Shelter	Unfounded	No
	Aunt/Uncle, Female, 16 Years	Father, Male, 22 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Aunt/Uncle, Female, 16 Years	Grandparent, Male, 53 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Deceased Child, Male, 11 Months	Grandparent, Female, 44 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Deceased Child, Male, 11 Months	Grandparent, Female, 44 Years	Inadequate Guardianship	Unfounded
Aunt/Uncle, Female, 16 Years	Father, Male, 22 Years	Inadequate Guardianship	Unfounded
Deceased Child, Male, 11 Months	Grandparent, Male, 53 Years	Inadequate Food / Clothing / Shelter	Unfounded
Deceased Child, Male, 11 Months	Grandparent, Male, 53 Years	Inadequate Guardianship	Unfounded
Aunt/Uncle, Female, 16 Years	Grandparent, Female, 44 Years	Inadequate Guardianship	Unfounded
Deceased Child, Male, 11 Months	Father, Male, 22 Years	Inadequate Guardianship	Unfounded
Aunt/Uncle, Female, 16 Years	Grandparent, Male, 53 Years	Inadequate Guardianship	Unfounded
Aunt/Uncle, Female, 16 Years	Grandparent, Female, 44 Years	Inadequate Food / Clothing / Shelter	Unfounded

Report Summary:
SCR report alleged the SC, 11-months-old, lived with SM and visited BF and PGPs. The PGP's home was alleged to be in a deplorable condition and posed a health hazard to the SC and the 15-year-old PA.

Determination: Unfounded | **Date of Determination:** 07/30/2014

Basis for Determination:
MCDSS unsubstantiated the allegations against the BF and the PGPs due to a lack of credible evidence being gathered to support the allegations. The home was observed to contain no safety hazards and the CHN were observed to be safe in the home.

OCFS Review Results:
MCDSS observed the SC and other child residing in the home, and interviewed the SM, Stepmother, BF, PGPs, MA, as well as other family members. The CHN appeared well cared for and the home was observed to contain no safety hazards and the appropriate supplies for the CHN. MCDSS spoke to collaterals including Early Intervention and the CHN's pediatricians. The SCR history was reviewed and the safety assessments and RAP were completed accurately and on time. The case was closed with no service needs identified.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/07/2014	Deceased Child, Male, 7 Months	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes

Report Summary:
SCR report alleged the SM did not have the SC, 7-months-old, appropriately dressed for the weather on 1/7/14 and was outside with the SC for at least 15 minutes.

Determination: Unfounded | **Date of Determination:** 03/05/2014

Basis for Determination:
MCDSS unsubstantiated the allegation against the SM due to a lack of credible evidence being gathered to support the allegations. The SC was observed to have adequate food, clothing and shelter. The SC was reported to be wearing a snow suit at the time of the incident. The SC was determined to be safe and there were no concerns gathered for the child.

OCFS Review Results:
MCDSS interviewed the SM, Stepmother and other family members. MCDSS reviewed the pediatrician records and there were no concerns for the SM's care of the SC. The SC was observed on several occasions and appeared well cared for, the home was observed to contain no safety hazards and the appropriate supplies were observed for the SC. Safe sleep was discussed and SCR history was reviewed. The safety assessments and the RAP were completed accurately and on time. A notice of existence was sent to BF, although attempts were not made to interview him. The case was closed with no service needs identified.

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

Issue:
Adequacy of face-to-face contacts with the child and/or childs parents or guardians

Summary:
BF was added to the report as a parent and notified about the investigation. Although he visited the SC, there was no effort to interview him.

Legal Reference:
432.1 (o)

Action:
MCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a 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.

[redacted]

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

An SCR report was received on 3/20/10 and was substantiated for the allegation of IG and unsubstantiated for the allegations of CD/A and SA against SM's partner regarding his 16 yo girlfriend at the time.

An SCR report was received on 3/31/09 and was unsubstantiated for the allegations of IG and IFCS against SM and Stepmother regarding SM's niece.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

Foster Care Placement History

The 1 yo SS was removed and placed in Foster Care on 1/26/17 and an Article 10 Neglect Petition was filed due to concerns the SM, her partner and the SS moved into a home that was condemned, there was ongoing DV in the presence of the SS and SM left the SS with a family member and failed to return to pick him up.

The newborn SS was removed and placed in foster care on 8/25/17 and an Article 10 Neglect Petition was filed due to concerns for ongoing DV in the presence of the SS and the OP that barred SM's partner from the SS was violated.

Both SS remained in Foster Care at the time this report was written. Berkshire Farm Center and Services for Youth monitored the case. Foster Care regulations were followed for casework contacts and permanency planning for the CHN. The most recent FASP was completed accurately and on time, although no service plan review was documented.

Legal History Within Three Years Prior to the Fatality

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

Additional Local District Comments

Montgomery County DSS is not aware of the deceased child having visitation with his biological father at his home at the time of the child's passing. The biological father was not listed on the original report at the time of intake and was later added by a Montgomery County Caseworker. Appropriate collateral notification was made in the form of a Notice of Existence letter. Montgomery County did not receive any response to the Notice of Existence nor was the letter returned as undeliverable. At no time during the course of this investigation, which took place three years post mortem, was any Caseworker informed that the biological father of this child was seeing or having any contact with him prior to his death. The child's biological father was not present during the incident and therefore would be unable to provide any additional information in that regard. Montgomery County CWs interviewed all individuals present on the date that the incident took place. Based on prior guidance by New York State Office of Children and Family Services regarding the necessity of face to face contacts, the timeline of this investigation in comparison to the child's actual date of death, and the limited contact between biological father and child, Montgomery County did not think it necessary to consider notification beyond what is required for a collateral contact. This notification was successfully completed.

OCFS disagrees with DSS' conclusions.

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