Child Fatality Report

Report Identification Number: BU-17-017

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

Issue Date: Dec 26, 2017

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Chautauqua
Gender: Female
Date of Death: 07/09/2017
Initial Date OCFS Notified: 07/09/2017

Presenting Information

On 7/9/17, SC died while in the care of her mother and grandmother. SC was found to have two large bruises on her buttocks. SC's throat was swollen and as a result of this, she could not be intubated. SC was an otherwise healthy child. SS (age 2) had an unknown role.

Executive Summary

The SCR received a report on 7/9/17 alleging DOA/Fatality & IG against SM & MGM for SC, LMC against SM for SC, and IG against SM for SS. Chautauqua County Department of Health and Human Services (CCDHHS) began their investigation and coordinated efforts with LE upon receipt of this report. Living in the home at the time were SM, SC, MGM and her 12yo son (MU) and 9yo daughter (MA). CCDHHS saw and assessed the safety of all surviving CHN in the home.

The investigation revealed that on 7/9/17, SM, SS, and SC slept together in the same bed. MGM slept downstairs, and her CHN were with a relative for the night. SM fed SC between 6:15-7AM, changed her diaper, and placed her back in bed. SC was wrapped in a blanket, placed on her side, propped on a pillow near the corner in SM's bed. Around 9AM, SM brought SS to the bathroom and SM reported SC to be awake with her eyes open at that time. SM reports she came back approximately 10 minutes later and discovered SC on her side and unresponsive. SM and MGM called 911 who gave instructions to perform CPR on SC. First responders arrived shortly after and continued CPR. SC was transported to a hospital and pronounced dead at 9:44AM. MGM and SS were the only other people home at the time, and MGM provided the same account.

It was initially suspected SC sustained inflicted injuries; bruising to her buttocks and a throat that was swollen shut. As a result, SS, MU, and MA were removed from the home on 7/9/17. SS was briefly in foster care and MU and MA were placed with a relative on 7/9/17. MGGM petitioned for and was awarded custody of all three CHN on 7/11/17. BF2 (father of SS) was unable to plan for SS as he was incarcerated. BF2 had no appropriate relative resources.

On 7/11/17, CW spoke with ME, who reported the death appeared to be a result of positional asphyxiation due to co-sleeping. SC had fixed anterior lividity, which meant SC had been dead "for a while" and her position at death was face down. ME noted SC had severe diaper rash but otherwise appeared healthy with no evidence of inflicted trauma. SC had Mongolian spots on her buttocks which were originally mistaken for bruises. ME said if SC was unable to be intubated it was because rigor had already set in. ME reported SM's timeline of events was not plausible. ME was not overly concerned with a time frame of 2 hours, if SM said she fed SC around 6:45AM and then found SC unresponsive about 9AM.

CCDHHS obtained hospital records which documented SM was educated on safe sleep at the birth of SC. CW also verified with SC's primary Dr. that SM was educated on safe sleep several times, as SM reported she would place SC on her side to sleep. SM had a bassinet that was full of items and this is why she placed SC in her bed to sleep.

CW obtained photographs and documentation from LE. CW spoke with several collaterals such as EMS, LE, Fire Department, primary Dr., emergency room medical providers, ME, BF, and relatives. CW offered appropriate services such as bereavement counseling. At the time of case closing, family had not engaged in counseling. SM was working on her education through a teenage parenting program. CHN remained in the care of MGGM.

CCDHHS appropriately substantiated the allegations of DOA/Fatality and IG against SM for SC, and IG for SS. Allegations against MGM were unfounded. The report was indicated on 9/7/17. An abuse petition in Family Court was pending and the case remains open with preventive services. The petition was filed due to the discrepancy in SM's timeline of events the day of the fatality, bed sharing with both children, and SM's failure to obtain and administer SC's prescribed medication.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? Yes

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

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

Explain:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Some progress notes were entered up to 50 days after the receipt of information.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/09/2017 **Time of Death:** 09:44 AM

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

County where fatality incident occurred: Chautauqua
Was 911 or local emergency number called? Yes
Time of Call: 09:06 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: 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	Aunt/Uncle	No Role	Female	9 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	12 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	39 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Other Household 1	Other Adult - BF of SS	No Role	Male	19 Year(s)
Other Household 2	Father	No Role	Male	20 Year(s)
Other Household 3	Grandparent	No Role	Female	57 Year(s)

LDSS Response

On 7/9/17, CCDHHS began their investigation, coordinating efforts with LE. LE reported the circumstances surrounding SC's death were suspicious, as her throat was too swollen to be intubated. CW met with LE, the DA, and assistant DA.

CW was provided with SM's statement.

CW visited the home on 7/9/17 and spoke with SM and MGM about removing SS and SM's siblings (MU and MA, ages 12 & 9). CW discussed 1021 placement of SS; SM refused to give consent. CW explained the imminent risk of harm to the CHN (SC was originally thought to have inflicted injuries), and a 1024 removal was completed. SS was not home at the time but a relative would later return him to the home. SS's father (BF2) was incarcerated and could not plan for his care. CW completed an alternate caregiver plan for MGM's children (MU & MA) to go with an uncle and his girlfriend (GF). The uncle and GF gave consent for an SCR clearance to be completed; no concerns noted. CW's visited the uncle's home later this day and assessed it to be safe for the CHN. When SS arrived home, he was taken by CWs to a hospital to be examined. SS was assessed and cleared, showing no signs of injury. SS was then transported to a foster home. SS was not originally placed with the uncle because the SS was not home at the time and the family was not being forthcoming about the location of the SS.

SM said SC had difficulty with formula and changed formulas several times. As a result, SC had chronic diarrhea which led to severe diaper rash. SM brought SC to her Dr. last week due to this and feeding issues. CW verified this information by speaking with SC's Dr.'s office. CW reviewed Dr.'s notes where SM told the Dr. she placed SC on her side to sleep. Dr. had several discussions with SM and educated her surrounding safe sleep.

CW visited BF2 who was in county jail. BF2 had no concerns with SM's care of SS, and had no appropriate relative resources for SS.

SM provided CW with a timeline of events for 7/9/17. SM said she was on her porch until 4AM and then went inside to go to bed. SM got SC out of her swing in the living room, and SS from the couch, and they all went to sleep in the same bed. SS was on the inside against the wall, SC in the middle, and SM on the outside. SM fed SC between 6:15-7AM, changed her diaper, and placed her back in bed. SM said she placed SC on her side on a pillow next to the corner of the bed (SM gave varying accounts of whether she placed SC on her side or back). Sometime later, SS started to wake up. SM took SC with her to go make a bottle for SS. SM and SC came back to the room and SM propped SC on her back on a pillow next to the corner. SS got up around 9AM and SM took him to the bathroom. When she returned approximately 10-15 minutes later, SC "looked a different color, not quite purple." SM said SC must have moved herself because she was found completely on her side. SC was wearing a onesie and was swaddled in a blanket. SM picked SC up and she did not move. SM screamed for MGM and 911 was called. MGM was instructed to do CPR. SM took SS outside to wait for EMS. SC was then transported to the hospital. CW interviewed MGM and she gave the same account as SM.

BF was interviewed on 8/29/17. BF would take SC to his home for visits. BF was scheduled to have a visit with SC the day after she died. BF had no further information.

On 7/11/17, MGGM was awarded temporary custody of SS, MU & MA. CW offered grief services to the family, and they said they would consider it. Family Court Judge did not issue court ordered services; SM agreed to preventive services with CCDHHS. CW spoke with all appropriate collaterals including LE, Dr., MA, Hospital staff, and first responders.

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: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042841 - Deceased Child, Female, 1 Mons	042849 - Mother, Female, 18 Year(s)	Lack of Medical Care	Substantiated
042841 - Deceased Child, Female, 1 Mons	042842 - Grandparent, Female, 39 Year(s)	DOA / Fatality	Unsubstantiated
042841 - Deceased Child, Female, 1 Mons	042849 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Substantiated
042841 - Deceased Child, Female, 1 Mons	042842 - Grandparent, Female, 39 Year(s)	Inadequate Guardianship	Unsubstantiated
042841 - Deceased Child, Female, 1 Mons	042849 - Mother, Female, 18 Year(s)	DOA / Fatality	Substantiated
042843 - Sibling, Male, 2 Year(s)	042849 - Mother, Female, 18 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐
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:
Some progress notes were entered up to 50 days after the event date.

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:
A 1024 removal was done and SS was placed in foster care. SC was originally thought to have inflicted injuries. MGGM later filed for and obtained custody of SS.

Legal Activity Related to the Fatality

Was there legal activity as a result of 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:**
07/28/2017	There was not a fact finding	There was not a disposition
Respondent:	042849 Mother Female 18 Year(s)	
Comments:	CCDHHS would not agree to a permanent order of custody to MGGM. Temporary custody with MGGM was continued. SM had to be re-referred to the Public Defender's office. Next appearance schedule for 9/18/17.	

Have any Orders of Protection been issued? Yes	
From: 07/11/2017	**To:** Unknown
Explain: The Family Court Judge issued a temporary order of protection with specific language that all CHN are to have their own sleeping arrangements and the CHN must sleep with no one else in their beds.	

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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? 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)	Status/Outcome	Compliance Issue(s)
05/26/2015	Mother, Female, 16 Years	Grandparent, Female, 37 Years	Inadequate Guardianship	Indicated	Yes
	Mother, Female, 16 Years	Grandparent, Female, 37 Years	Lack of Medical Care	Indicated	

Report Summary:
SM was diagnosed with depression prior to giving birth to her son SS (1 month old). Since then, her depression became worse, which interfered with her ability to bond and care for SS. MGM was made aware of the concerns and failed to ensure SM received proper MH treatment.

Determination: Indicated	**Date of Determination:** 07/22/2015

Basis for Determination:
SC was frequently running away from the home, staying from place to place and not keeping her MH appointments. CW spoke with several collaterals who all confirmed SM was missing her MH appointments and not consistently taking her MH medication. MGM would frequently tell SM to kill herself. SC would lose her benefit card and be unable to provide food for herself.

OCFS Review Results:
CW worked diligently to find alternate housing for SM and SS to avoid being removed; however, SM failed to stay at her alternate place of living. SM was non-compliant with agreed upon plans and could not keep herself or SS safe. CW appropriately filed a neglect petition against MGM and as a result, SM and SS were placed in foster care. CW worked to provide several supports to the family and frequently assessed safety of all CHN.

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

Issue:
Failure to provide safe sleep education/information

Summary:
CW did not provide SM with safe sleep education for her newborn child.

Legal Reference:
13-OCFS-ADM-02

Action:
As part of any CPS investigation in which there is an infant in the household, irrespective of the allegations or the role of the infant, CPS staff must provide the parent or caregiver with information on safe sleep, including the risks of bed-sharing. The CPS worker must document what information was provided to the parent or caretaker and when it was provided.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/22/2015	Mother, Female, 16 Years	Grandparent, Female, 37 Years	Educational Neglect	Unfounded	No
	Mother, Female, 16 Years	Grandparent, Female, 37 Years	Inadequate Guardianship	Unfounded	

Report Summary:
SM (16 at the time) missed 34 days of school and was failing a majority of her classes. MGM was aware and failed to intervene.

Determination: Unfounded	**Date of Determination:** 03/14/2015

Basis for Determination:
SM did have excessive absences; however, she was pregnant and able to provide several medical excuses. During the course of the investigation the child's grades significantly improved. Home tutoring was set up for SM for after the birth of SS. SM was involved in several services such as MH counseling, SPOA, and PINS.

OCFS Review Results:
All three children were seen the day the report was accepted and assessed as safe. All notifications mailed, safety assessed accurately and on time, CPS history was reviewed, and several collaterals were contacted such as MH providers for SM, and school officials. SM's attendance continued to be inconsistent; however, she was 7-months-pregnant at the time. CCDSS made the appropriate determination as the child was no longer failing at the case closing.

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)
07/09/2014	Mother, Female, 15 Years	Grandparent, Female, 36 Years	Inadequate Guardianship	Indicated	Yes
	Mother, Female, 15 Years	Grandparent, Female, 36 Years	Parents Drug / Alcohol Misuse	Indicated	
	Mother, Female, 15 Years	Grandparent, Female, 36 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:
On 7/9/14, MGM was intoxicated, and pulled a knife on SM (15yo at the time). MGM threatened to cut SM, and proceeded to hit SM multiple times. As a result, SM sustained bruises all over her back, and a laceration that appeared to have been from a fingernail.

Determination: Indicated | **Date of Determination:** 11/26/2014

Basis for Determination:
SM stated she wasn't worried when her mother pulled the knife as she knew she wouldn't hurt her with it. SM denied having marks or injuries from the incident but did say her mother (MGM) was intoxicated. CW did not observe SM to have any marks or bruises. SM did not feel as if she were in danger at any point during the investigation.

OCFS Review Results:
CW provided MGM with a community resource list and a phone number for probation to call about PINS as MGM was having a difficult time handling SM. CW contacted appropriate collaterals including LE, relatives, and MH agencies. Family was involved with four different agencies when the case closed. CW appropriately determined the report.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
Several case notes were entered 1-3 months after the event date.

Legal Reference:
18 NYCRR 428.5

Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

[redacted]

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

10/20/04-12/14/04 IND allegations of IG & PD/AM against MGM for MU
9/7/13-9/18/13 UNF allegations of IG, PD/AM, & LS against MGM for SM, SC, and MU
4/7/14-6/11/14 UNF allegations of IG & L/B/W against MGM for SM

Known CPS History Outside of NYS

There is no CPS history outside of NYS.

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