# Child Fatality Report

**Report Identification Number: BU-16-030**

**Prepared by: Buffalo Regional Office**

**Issue Date: Apr 13, 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 | |

| 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 |
| CPR-Cardio-pulmonary Resuscitation | | |
| **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-Others | |
| **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 | |

## Case Information

**Report Type:** Child Deceased
**Age:** 1 year(s)
**Jurisdiction:** Chautauqua
**Gender:** Unknown
**Date of Death:** 10/15/2016
**Initial Date OCFS Notified:** 10/17/2016

## Presenting Information

On the morning of 10/15/2016, one-year old subject child (SC) died in a fire in his home, where he resided with subject mother (SM) and surviving siblings (SS1) age four and (SS2) age three. Subject child's body was found in his bed. There is no official cause of death at this time and it is unknown how the fire started. SS1 and SS2 were also home at the time of the fire, but managed somehow to escape the home and were not harmed or injured. It is unclear how this occurred as the fire was so severe. Firefighters had difficulty getting into the home. Subject mother was the sole caretaker of all three children at the time of the incident. There were inconsistencies in subject mother's account of the incident. There is a history of SM frequently leaving all three children home alone for unknown lengths of time. She was not present to help the children out of the home at the time of the fire. Subject child's father has an unknown role at this time.

## Executive Summary

This fatality case review involved a house fire death of a one-year-old child in an open preventive services case. An SCR report was made with allegations of DOA/Fatality, Lack of Supervision, and IG against subject mother (SM) alleging she had left the children home alone at the time of the fire.

The Caseworker made appropriate case and collateral contacts. Medical information was obtained, SCR check made, and the status of the two surviving siblings was assessed and a temporary voluntary safety plan made for the two surviving siblings to be in the care of their maternal grandmother.

Subject mother reported she had put an electric space heater in the children’s bedroom around 4AM. She reported that gas service is included with her rent, but that she is not allowed to use it for heat and that the landlord provided the electric space heaters. SM reported putting all three of the children to sleep in the same bed and covering them with blankets. SM reported awakening to the smell of smoke. SM reported repeatedly trying to enter the children’s bedroom, but was blown back by hot flames and smoke and became disoriented. Neighbors and family members also tried to enter the room without success.

Fire personnel reported that subject child was dead at the scene, was found face down in a different bed than where subject mother reported she had put him to sleep, and the back of his body was charred from the fire that had fully combusted all items in the room. The electric heater had been found unplugged, but was cited as the likely cause of the fire. It is theorized that subject child or fire fighters may have tripped on the cord pulling it from the wall. SS1, age four years, and SS2, age three years, had gotten themselves out of the bedroom and were taken outside and then taken to the hospital by first responders for treatment of smoke inhalation.

The SCR report alleged that the subject mother had not been present in the home when the fire started. First responders, Fire Investigators, and Law enforcement concluded there was no evidence to support this. Subject mother was observed on the scene covered in black soot, and neighbors/family reported she had been observed present. There were multiple code violations found at the home, but no criminal charges were made. Only one smoke alarm was found in the home and it had no batteries.

The Erie County Medical Examiner performed an autopsy, but the final report was not available at the time of case closing or at the time of this case review. The preliminary results were that subject child died of smoke inhalation and secondary burns during the home fire.

On 12/11/2016, the allegations of DOA/Fatality, Lack of Supervision, and IG were unfounded against Subject mother. While the cause of the fire was undetermined, it is theorized by Fire Investigators that, at some point in the night, subject child moved into the other bed and may have dragged a blanket with him that accidentally draped over the electric heater and combusted starting the house fire. A preventive services case remains open with this family through a Family Court finding of Neglect dated 7/22/16 with an ACD continuing through July 2017.

## 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:**
N/A

**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:**
The case record contained insufficient external case documentation. Available criminal records, death certificate, EMS run sheet, list of code violations, fatality scene photos, school records, and other important documentation was not obtained. While the CW obtained consents to obtain various records, there was a lack of follow through to obtain the above noted documentation.

## Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Overall Completeness and Adequacy of Investigation |
| **Summary:** | The case record contained insufficient external case documentation. Available criminal records, |

| | |
|---|---|
| | death certificate, EMS run sheet, list of code violations, fatality scene photos, school records, and other important documentation was not obtained. |
| **Legal Reference:** | SSL 424(6); 18 NYCRR 432.2(b)(3) |
| **Action:** | All pertinent documentation records must be obtained to support the determination of the case record, risk factors, and safety assessment of the family's status at the time of the fatality incident, during the investigation, and at case closing. |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 10/15/2016 **Time of Death:** Unknown

**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:** Unknown
**Did EMS to 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
**How long before incident was the child last seen by caretaker?** 4 Hours
**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 | Deceased Child | Alleged Victim | Male | 1 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 21 Year(s) |
| Deceased Child's Household | Sibling | Alleged Victim | Female | 3 Year(s) |

| | | | | |
|---|---|---|---|---|
| Deceased Child's Household | Sibling | Alleged Victim | Male | 4 Year(s) |
| Other Household 1 | Father | No Role | Male | 30 Year(s) |

**LDSS Response**

On 10/21/2016, Chautauqua County CPS received an SCR report on a family with an open services case with allegations of DOA/Fatality, Lack of Supervision, and IG against subject mother (SM) stemming from subject child's (SC) death in a house fire.

The Caseworker initiated the investigation making appropriate case and collateral contacts. Medical information was obtained, SCR check made, and the status of the two surviving siblings was assessed and a safety plan made. The two surviving siblings were temporarily in the care of their maternal grandmother following the fire incident through a voluntary agreement made between SM and MGM.

First responders reported subject child, age one year, was found face down in a bed in a bedroom that had been fully engulfed with flames and smoke. Family members and subject mother had made multiple attempts to retrieve the child, but were unable to enter the bedroom due to the flames and heavy smoke. SS1, age four years, and SS2, age three years, had gotten themselves out of the bedroom and were taken outside prior to first responder arrival and then taken to the hospital by first responders for treatment of smoke inhalation.

Subject mother reported she had put an electric space heater in the children's bedroom around 4AM after hearing a child coughing. She reported that gas service is included with her rent, but that she is not allowed to use it for heat and that the landlord provided the electric space heaters. SM reported putting all three of the children to sleep in the same lower bed of the bunk bed and covering them with blankets. SM reported awakening to the smell of smoke and when she got up there was black smoke everywhere. SM reported repeatedly trying to enter the children's bedroom, but was blown back by hot flames and smoke and became disoriented. Neighbors and family members also tried to enter the room without success.

Fire personnel reported that subject child was dead at the scene. He had been found face down in a different bed than where subject mother reported she had put him to sleep and the back of his body was charred from the fire that had fully combusted all items in the room. The electric heater had been found unplugged, but was cited as the likely cause of the fire. It is theorized that subject child or fire fighters may have tripped on the cord pulling it from the wall. Subject Mother had been suspected of not being present in the home when the fire started. First responders, Fire Investigators, and Law enforcement concluded there was no evidence to support this. Subject mother was observed on the scene covered in black soot, and neighbors/family reported she had been observed present. There were multiple code violations found at the home, but no criminal charges were made. Only one smoke alarm was found in the home and it had no batteries. A Go-fund-me account was started by friends/family and the proceeds were used to purchase a car and furniture for subject mother and the family's new home. The father of SS1 and SS2 reported generalized concerns regarding subject mother, but could not provide any supporting information.

The Erie County Medical Examiner performed an autopsy, but the final report was not available at the time of case closing or at the time of this case review. The preliminary results were that subject child died of smoke inhalation and secondary burns during the home fire.

On 12/11/2016, the allegations of DOA/Fatality, Lack of Supervision, and IG were unfounded against Subject mother. While the cause of the fire was undetermined, it is theorized by Fire Investigators that, at some point in the night, subject child moved into the other bed and may have dragged a blanket with him that accidentally draped over the electric heater

and combusted starting the house fire. A preventive services case remains open with this family through a Family Court finding of Neglect dated 7/22/16 with an ACD continuing through July 2017.

## 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
**Comments:** The fatality case was reviewed by Chautauqua County's Multidisciplinary Team and appropriate protocols for a joint investigation with law enforcement were followed.

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?** No
**Comments:** Chautauqua County Department of Social Services does not have an OCFS approved Child Fatality Review Team.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 035301 - Deceased Child, Male, 1 Yrs | 035421 - Mother, Female, 21 Year(s) | Lack of Supervision | Unsubstantiated |
| 035301 - Deceased Child, Male, 1 Yrs | 035421 - Mother, Female, 21 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 035301 - Deceased Child, Male, 1 Yrs | 035421 - Mother, Female, 21 Year(s) | DOA / Fatality | Unsubstantiated |
| 035422 - Sibling, Male, 4 Year(s) | 035421 - Mother, Female, 21 Year(s) | Lack of Supervision | Unsubstantiated |
| 035422 - Sibling, Male, 4 Year(s) | 035421 - Mother, Female, 21 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 035423 - Sibling, Female, 3 Year(s) | 035421 - Mother, Female, 21 Year(s) | Lack of Supervision | Unsubstantiated |
| 035423 - Sibling, Female, 3 Year(s) | 035421 - Mother, Female, 21 Year(s) | Inadequate Guardianship | Unsubstantiated |

## CPS Fatality Casework/Investigative Activities

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **All children observed?** | ☒ | ☐ | ☐ | ☐ |
| **When appropriate, children were interviewed?** | ☒ | ☐ | ☐ | ☐ |
| **Alleged subject(s) interviewed face-to-face?** | ☒ | ☐ | ☐ | ☐ |
| **All 'other persons named' interviewed face-to-face?** | ☒ | ☐ | ☐ | ☐ |
| **Contact with source?** | ☒ | ☐ | ☐ | ☐ |
| **All appropriate Collaterals contacted?** | ☐ | ☒ | ☐ | ☐ |
| **School** | ☐ | ☒ | ☐ | ☐ |
| **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:**
Death scene investigation was completed by CW review of available photographs from law enforcement/ fire investigation.

The family continues to have an open preventive services case through a finding of Neglect with ADC through July 2017.

**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 siblings/other children in the household removed as a result of this fatality report/investigation?** | ☐ | ☒ | ☐ | ☐ |
| **Explain as necessary:** No children were removed as a result of this fatality investigation. | | | | |

## 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 | Needed but not Offered | Needed but Unavaliable | 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:** Toys for Tots referral.

**Additional information, if necessary:**
The two surviving siblings temporarily stayed in the care of the maternal grandmother following the fatality incident. Counseling and daycare services were offered to subject mother and were accepted. Because many of the children's toys were lost in the fire, a referral was made by the CW to Toys for tots. A Go-fund-me account was started by friends/family and purchased a car and furniture.

**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:**
A temporary voluntary plan was made between subject mother and the maternal grandmother for the two surviving siblings to be in the MGM's care. Day care services were offered and accepted.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
The open preventive services CW provided on-going support and monitoring for the family. Counseling services were offered and accepted for subject mother.

## 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) |
|---|---|---|---|---|---|
| 04/15/2016 | 14198 - Deceased Child, Male, 4 Months | 14199 - Mother, Female, 19 Years | Inadequate Food / Clothing / Shelter | Unfounded | No |
| | 14198 - Deceased Child, Male, 4 Months | 14199 - Mother, Female, 19 Years | Inadequate Guardianship | Unfounded | |

**Report Summary:**
Four month old subject child was born two months prematurely. It is imperative that subject child be fed daily in order for him to gain weight. The subject mother ran out of her WIC, but still had food stamps. Instead of getting formula with her food stamps, she fed subject child sugar water for at least two days. The subject mother is unable to provide adequate care for this infant.

**Determination:** Unfounded | **Date of Determination:** 08/27/2015

**Basis for Determination:**
Subject mother was low on formula, but was able to secure formula and subject child did not go without any meals. The feeding of sugar water to subject is denied and unable to be proven. Adequate supplies for subject child are observed. Monitoring of subject child's medical needs continues. All three children appear safe at this time.

**OCFS Review Results:**
No concerns upon BRO OCFS review.

**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) |
|---|---|---|---|---|---|
| 03/04/2016 | 14182 - Deceased Child, Male, 1 Minutes | 14181 - Mother, Female, 21 Years | Lack of Medical Care | Indicated | No |
| | 14184 - Sibling, Female, 2 Years | 14181 - Mother, Female, 21 Years | Lack of Medical Care | Indicated | |
| | 14183 - Sibling, Male, 3 Years | 14181 - Mother, Female, 21 Years | Lack of Medical Care | Indicated | |

**Report Summary:**
Subject child, age 1, has a history of lung and respiratory issues. Subject child has also been hospitalized in the past. Today 3/4/16, the child had high respiration rates, low oxygen levels, and a rubbing noise was heard in the right side of his chest. The rubbing noise can either be asthma or pneumonia. The subject mother is failing to provide the child with two asthma medications. Due to these issues, the subject mother was advised to get the child checked by medical staff.

The subject mother has failed to seek medical help for the child. The subject child has also missed several appointments. SS1 and SS2 have also missed their well visit check-up appointments and immunizations.

**Determination:** Indicated | **Date of Determination:** 07/15/2016

**Basis for Determination:**
There is credible evidence to support allegations of IG and Lack of Medical Care. CW had to intervene to convince subject mother to seek medical attention for subject child. Subject mother did not believe subject child needed medical attention, but subject child was subsequently diagnosed with pink eye and an ear infection and required antibiotics. Several medical appointments have been missed for the children. There is a pending Neglect petition before Family Court. The family continues to receive preventive services to assist subject mother's accessing medical care for the children which will continue to be monitored.

**OCFS Review Results:**
No concerns upon BRO OCFS review.

**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) |
|---|---|---|---|---|---|
| 03/04/2016 | 14185 - Deceased Child, Male, 1 Years | 14186 - Mother, Female, 20 Years | Inadequate Guardianship | Indicated | No |
| | 14185 - Deceased Child, Male, 1 Years | 14186 - Mother, Female, 20 Years | Lack of Medical Care | Indicated | |
| | 14185 - Deceased Child, Male, 1 Years | 14188 - Father, Male, 29 Years | Inadequate Guardianship | Indicated | |
| | 14185 - Deceased Child, Male, 1 Years | 14188 - Father, Male, 29 Years | Lack of Medical Care | Indicated | |

**Report Summary:**
One year old subject child had a medical condition that affects his lungs. Subject child needed prescription medication and regular medical exams, however subject mother and father inconsistently give subject child his medication and frequently miss medical appointments. Subject child was having respiratory issues and needed emergency medical care, however the parents did not seeking out treatment. SS1 and SS2 have unknown roles. Father has unknown role.

**Determination:** Indicated | **Date of Determination:** 07/15/2016

**Basis for Determination:**
This was a subsequent report.
There is credible evidence to support allegations of IG and Lack of Medical Care. CW had to intervene to convince subject mother to seek medical attention for subject child. Subject mother did not believe subject child needed medical attention, but subject child was subsequently diagnosed with pink eye and an ear infection and required antibiotics. Several medical appointments have been missed for the children. There is a pending Neglect petition before Family Court. The family continues to receive preventive services to assist subject mother's accessing medical care for the children which will continue to be monitored.

**OCFS Review Results:**
No concerns upon BRO OCFS review.

**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) |
|---|---|---|---|---|---|
| 01/15/2016 | 14261 - Deceased Child, Male, 1 Years | 14262 - Mother, Female, 21 Years | Lack of Medical Care | Indicated | No |

| | | | | |
|---|---|---|---|---|
| | 14261 - Deceased Child, Male, 1 Years | 14262 - Mother, Female, 21 Years | Inadequate Guardianship | Indicated |

**Report Summary:**
Subject child, age 13 months old, has had a series of medical issues associated with respiratory distress, pneumonia, and seizures since he was born prematurely. Subject child has a chronic lung disease and has needed to be assessed at the Lung Center for breathing issues. The subject mother has not followed up with the high level of medical needs that subject child requires for his health and safety. Subject mother has missed taking him to many of these appointments as she claims she cannot afford the cover or co-pays even though her medical insurance does not require any covers or co-pays.

**Determination:** Indicated | **Date of Determination:** 02/01/2016

**Basis for Determination:**
There is credible evidence to support the allegations of IG and Lack of Medical care. Subject child discharged from PICU on 1/18/16 and was unable to receive follow-up care as the Pediatrician's care had been ended in 11/15 due to missed appointments. Subject child received no medical care since 6/2015 and has had no well-child visits or recommended immunizations since 4/2015. Subject child has also had no follow-up care from WCH Lung Center since 3/2015. Subject mother admitted to lack of medical care reporting she did not maintain appointments due to owing money to Doctor offices. This case is open with preventive services and a Neglect Petition has been filed in Family Court.

**OCFS Review Results:**
BRO OCFS agrees with Neglect Petition and supports case actions.

**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) |
|---|---|---|---|---|---|
| 06/08/2015 | 14202 - Deceased Child, Male, 6 Months | 14201 - Father, Male, 26 Years | Inadequate Guardianship | Unfounded | No |

**Report Summary:**
Today 6/18/2015, father kicked in the front door while holding subject child, age six months. The child is medically fragile. Subject child was born prematurely and requires anti-seizure medication. father then pushed subject mother into a table/desk while he was still holding the child. Subject mother tried to take the child from father, but father shook his fist at her in a threatening manner. Subject mother has unknown role.

**Determination:** Unfounded | **Date of Determination:** 09/21/2015

**Basis for Determination:**
Both parents independently reported the same information with subject child not being involved, no door getting kicked in, and only a verbal argument occurring. There was Police intervention with no arrest. SS1 and SS2 were on visitation with their father and not at the home. All children appear safe.

**OCFS Review Results:**
No concerns upon BRO OCFS review.

**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) |
|---|---|---|---|---|---|
| 06/16/2014 | 14193 - Sibling, Female, 9 Months | 14192 - Stepfather, Male, 23 Years | Inadequate Guardianship | Unfounded | No |
| | 14193 - Sibling, Female, 9 Months | 14192 - Stepfather, Male, 23 Years | Lack of Supervision | Unfounded | |
| | 14194 - Sibling, Female, | 14192 - Stepfather, Male, | Inadequate | Unfounded | |

| | | | |
|---|---|---|---|
| 1 Years | 23 Years | Guardianship | |
| 14194 - Sibling, Female, 1 Years | 14192 - Stepfather, Male, 23 Years | Lack of Supervision | Unfounded |

**Report Summary:**
Last night, father was intoxicated while he had SS1 and SS2 in his care. He was too intoxicated to provide adequate care or supervision for the children. The children were awake and outside at 10PM at night. SS1 wandered in the road as father was not watching him. When father noticed SS1 in the road he failed to go get him and escort him out of the road. Father is also noted to have a history of violence. Subject mother, Aunt, and cousin all have unknown roles.

**Determination:** Unfounded | **Date of Determination:** 06/17/2014

**Basis for Determination:**
Suspended/ Closed as a duplicate report.

**OCFS Review Results:**
No concerns upon BRO OCFS review.

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

[redacted]

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 06/15/2014 | 14266 - Sibling, Female, 1 Years | 14268 - Father, Male, 25 Years | Lack of Supervision | Unfounded | No |
| | 14267 - Sibling, Female, 2 Years | 14268 - Father, Male, 25 Years | Inadequate Guardianship | Unfounded | |
| | 14267 - Sibling, Female, 2 Years | 14269 - Mother, Female, 19 Years | Lack of Supervision | Unfounded | |
| | 14266 - Sibling, Female, 1 Years | 14268 - Father, Male, 25 Years | Inadequate Guardianship | Unfounded | |
| | 14267 - Sibling, Female, 2 Years | 14269 - Mother, Female, 19 Years | Inadequate Guardianship | Unfounded | |
| | 14267 - Sibling, Female, 2 Years | 14268 - Father, Male, 25 Years | Lack of Supervision | Unfounded | |
| | 14266 - Sibling, Female, 1 Years | 14269 - Mother, Female, 19 Years | Inadequate Guardianship | Unfounded | |
| | 14266 - Sibling, Female, 1 Years | 14269 - Mother, Female, 19 Years | Lack of Supervision | Unfounded | |

**Report Summary:**
Subject mother has been leaving SS2, age 1, and SS1, age 3, home alone at night for hours at a time. Subject mother goes down the street to hang out with friends. Subject mother also allows her boyfriend to sell and smoke marijuana around the children. The children are not bathed and changed enough.

**Determination:** Unfounded | **Date of Determination:** 08/04/2014

**Basis for Determination:**
No credible evidence to support the allegations of the report. Home visits found subject mother home. Subject mother was advised to remove a marijuana pipe and bottle of alcohol accessible to the children and did so. Subject mother and boyfriend not observed as intoxicated or appearing under the influence.

**OCFS Review Results:**
No concerns upon review.

**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) |
|---|---|---|---|---|---|
| 02/27/2014 | 14203 - Deceased Child, Male, 26 Days | 14204 - Mother, Female, 23 Years | Inadequate Food / Clothing / Shelter | Unfounded | No |
| | 14203 - Deceased Child, Male, 26 Days | 14205 - Father, Male, 25 Years | Inadequate Food / Clothing / Shelter | Unfounded | |

**Report Summary:**
Subject child, 1 month old, was born premature at thirty-three to thirty-four weeks gestation. Subject child spent approximately two weeks in the hospital. On December 23, 2014, the child weighed five pounds four ounces. He is eating on a regular and consistent basis. Today, December 29, 2014, the child still weighed five pounds four ounces and his temperature was ninety six degrees. The child was only dressed in a onesie. Subject mother and subject father only have two sleepers for the child and they are both dirty. Given that subject child was born prematurely, has not gained any weight in one week, and has a low temperature, he needs to be dressed in more than a onsie.

**Determination:** Unfounded | **Date of Determination:** 05/06/2015

**Basis for Determination:**
Medical personnel report no concerns of parental neglect that would result in subject child's medical issues. Subject child was born premature at 33 weeks gestation. Subject child is connected with Women's and Children Hospital regarding lung issues. Family has continued contacts with CPS to further monitor.

**OCFS Review Results:**
Upon review, BRO OCFS has no apparent concerns regarding this case.

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

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

09/19/2017 UNF 11/13/2013 Allegations of Excessive Corporal Punishment and Lack of Supervision Step-father, MA child other child. Adults and child denied child was outside past dark. Child denied all allegations. No credible evidence to support the allegations.

07/08/2013 UNF 08/21/2013 Allegations of IG and Parent Alcohol/Drug misuse against Subject mother and father, MA child SS1. Subject mother and father denied the allegations. No alcohol/Drugs observed in the home upon unannounced visits. Father acknowledged alcohol and marijuana use outside the home when not caretaker.

04/19/2013 UNF 04/22/2013 Allegations of IG and Parent Drug/Alcohol misuse against Subject mother, MA child SS1, Subsequent report to 4/18/13 report. Closed/consolidated.

04/18/2013 UNF 05/23/2013 Allegations of IG and Parent Drug/Alcohol misuse against Subject mother, MA child SS1. No credible evidence to support the allegations. Subject mother and father denied physical altercations and alcohol/drug abuse in the home.

03/31/2011 UNF 03/31/2011 Allegations of Educational Neglect against MGM, MA child Subject mother. 36 days of school absences. MGM attempting. PINS discussed. Child attending school when report received.

## Known CPS History Outside of NYS

This family had no known Child Protective history outside of New York State.

## Services Open at the Time of the Fatality

**Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality?** Yes
**Date the Child Protective Services case was opened:** 01/20/2016

### Evaluative Review of Services that were Open at the Time of the Fatality

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| Did the service provider(s) comply with the timeliness and content requirements for progress notes? | ☒ | ☐ | ☐ | ☐ |
| Did the services provided meet the service needs as outlined in the case record? | ☒ | ☐ | ☐ | ☐ |
| Did all service providers comply with mandated reporter requirements? | ☒ | ☐ | ☐ | ☐ |
| Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm? | ☐ | ☒ | ☐ | ☐ |

### Casework Contacts

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice? | ☒ | ☐ | ☐ | ☐ |
| Were face-to-face contacts with the child in the child's placement location made with the required frequency? | ☒ | ☐ | ☐ | ☐ |

### Services Provided

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| 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? | ☒ | ☐ | ☐ | ☐ |
| Were services provided to parents as necessary to achieve safety, permanency, and well-being? | ☒ | ☐ | ☐ | ☐ |

### Family Assessment and Service Plan (FASP)

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Was the most recent FASP approved on time?** | ☒ | ☐ | ☐ | ☐ |
| **Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?** | ☒ | ☐ | ☐ | ☐ |
| **Was the FASP consistent with the case circumstances?** | ☒ | ☐ | ☐ | ☐ |

## Closing

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Was the decision to close the Services case appropriate?** | ☐ | ☐ | ☒ | ☐ |

## Required Action(s)

**Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?**
☐Yes ☒No

## Preventive Services History

Tracks were opened for the three children on 1/20/2016 stemming from a Neglect Petition which was filed on 1/25/2016. There was a finding of Neglect on 1/22/2016 with an ACD for the family to receive preventive services through July 22, 2017. The subject child's track was closed on 10/15/2016 as the result of his death in the house fire.

## Casework Contacts

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Were face-to-face contacts with the child in the child's placement location made with the required frequency?** | ☒ | ☐ | ☐ | ☐ |

## Required Action(s)

**Are there Required Actions related to the compliance issues for provision of Foster Care Services?**
☐Yes ☒No

## Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

## 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:** |
| 01/25/2016 | There was not a fact finding | Adjourned in Contemplation of Dismissal (ACD) |
| **Respondent:** | 035421 Mother Female 21 Year(s) | |
| **Comments:** | The legals entered into CONNECTIONS by the local district show the children's track was opened 1/20/2016 and a Neglect Petition was filed on 01/25/2016. The legals do not show an adjudication for the Neglect Petition and only show the petition was "adjourned" on 2/2/16, 3/29/16, and 6/1/2016. Subject child's track was closed on 10/15/2016 due to death. SS1 and SS1 continue to be tracked with an open preventive services case. The case notes and case investigation summary document an adjudication of Neglect with an ADC on July 22, 2016 that runs through July 22, 2017 with preventive services in place. | |

## Additional Local District Comments

N/A

## Recommended Action(s)

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

| | |
|---|---|
| **Action:** | It is recommended that Chautauqua County CPS assess and address risk concerns in the physical environment of the home before open services cases are closed; including having adequate smoke/CO2 detectors per NYS building codes. This can be accomplished through referral of known deficiencies to local Building Code Enforcement Officers and/or CW taking appropriate steps to resolve all known risk factors. |

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

**Explain:** Per this case review, the home was documented in the case record as having inadequate smoke detectors at case closing that did not meet NYS fire safety codes. The CW was aware of code requirements for smoke detectors to be both inside and outside of all bedrooms, but the home at case closing, as documented in the case record, only had detectors in the kitchen and living room.

During the review, this matter was referred to the local district which facilitated an additional smoke and CO2 detector being placed in the home. While this is an improvement, the home continues to not be in

compliance with NYS fire safety codes. It is the landlord's responsibility to provide for adequate building code compliance.

It is recommended that the lack of adequate smoke detectors be referred to the area municipal Building Code Enforcement Officer and the open services CW to facilitate the resolution of this safety factor.