Child Fatality Report

Report Identification Number: BU-17-016

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

Issue Date: Dec 28, 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: 5 month(s)

Jurisdiction: Chautauqua
Gender: Male

Date of Death: 06/29/2017
Initial Date OCFS Notified: 07/03/2017

Presenting Information

An SCR report was received on 6/29/17 that alleged at around 8PM that night, SM was the sole caretaker of SC, and laid him down for a nap. SM then left to smoke a cigarette for approximately five minutes. When SM returned, a blanket was over SC's face and he was no longer breathing. Medical attention was immediately sought for SC. SC had no preexisting medical conditions, and the cause of death was unknown.

Executive Summary

This fatality report concerns the death of a 5-month-old male (SC) that occurred on 6/29/17. A report was made to the SCR on 6/30/17, with allegations of LS, IG, and DOA/Fatality against SM regarding SC. Chautauqua County Department of Social Services (CCDSS) conducted a thorough investigation surrounding SC's death. A final Autopsy Report was received on 11/17/17. The cause of death was noted as "acute bronchopneumonia in the setting of congenital subglottic stenosis", and the manner of death was "natural. The ME report indicated the examination revealed a "healthy male infant with no injures", and SC's "marked subglottic stenosis in combination with his early acute brochopneumonia would have compromised his breathing, thereby leading to his death."

SC was born five weeks premature, and at two weeks old was diagnosed with a medical condition; this did not require hospitalization and resolved itself. SC also had to see a specialist regarding two additional medical issues, but similarly, those issues resolved themselves as SC grew. SC was deemed healthy with no concerns at his four-month check-up. SC had no acute medical issues in the weeks leading up to his death. SM had three other children (SS), ages 6, 4, and 1 year old. The BF of SC and the youngest SS had been incarcerated since January 2017, and had only seen SC once during his lifetime. The biological father of the two older SS was actively involved in the children's lives but did not reside in SC's home. SM lived alone with her children at the time of SC's death.

On the date of the incident, it was discovered SM was home with SC and the 1-year-old SS in the evening hours; the other two SS were at soccer practice with OA. SM ran errands with the two children, and when they returned home, SM prepared a bottle for SC and placed him in a baby rocker with a blanket, unfastened. SM used the blanket to prop SC's bottle by his shoulder so he could eat while she went outside to smoke a cigarette; SM brought the SS with her outside. SM left SC unattended somewhere between 5 to 15 minutes, and when she returned inside the house, she found SC on his side, with his head covered by the blanket. SC was blue in color and not breathing. SM contacted 911 and EMS arrived on the scene. SC was pronounced dead at the hospital at 9:13PM.

From the time the investigation began to the time it was determined, CCDSS met regularly with the family, followed up with collateral contacts, assessed home environments of the children, and referred family members to grief and trauma services. A Neglect Petition was filed in Family Court based on SM's lack of supervision of SC, as well as concerns regarding SM's MH and drug use. CCDSS found credible evidence to substantiate the allegations of IG and LS against SM. CCDSS did not find evidence to substantiate for DOA/Fatality. The fatality investigation was indicated and closed and the case was opened for services.

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:
CCDSS gathered sufficient information to determine all allegations in the report.

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:
The casework was commensurate with the case circumstances. CCDSS gathered a wealth of information surrounding SC's death, and appropriately opened a services case in response.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/29/2017 **Time of Death:** 09:13 PM

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: 08:06 PM

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? No - but needed
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	5 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)
Other Household 2	Father	No Role	Male	24 Year(s)
Other Household 3	Other Adult - Older SS's BF	No Role	Male	30 Year(s)

LDSS Response

On 6/30/17, CCDSS received a report regarding the death of SC.CCDSS began their investigation within 24 hours, and coordinated with LE.The family was at MGF's home.A joint visit was made to assess the safety of the SS and begin gathering details surrounding SC's death.CCDSS observed the home, interviewed the verbal SS, and observed the 1yo SS;no concerns were noted.CCDSS contacted the source of the report, sent notifications, completed a CPS history check,and requested documentation from collateral contacts.It was determined the BF of SC and the 1yo had been incarcerated since January 2017.

On 6/30/17,CCDSS and LE visited SC's home. CCDSS observed a crib with a pillow in SM's bedroom. CCDSS found the home met minimal standards, and sleeping provisions were observed for all CHN.The CW reviewed case events with a supervisor;it was decided an alternative caregiver plan was necessary due to SM's mental state.It was agreed the SS would stay with MGM, MGM's husband, and MGGM, all of whom resided in the same home.It was determined SM could not be unsupervised with the SS, nor spend overnights at MGGM's home until further notice. Grief services were offered to the family and accepted.

Through interviews, it was learned on the evening of 6/29/17, SM was home with SC and the youngest SS;the older SS were picked up by their biological father around 6PM for soccer practice at school.SM went to a nearby store, taking SC and the youngest SS with her, but did not bring them inside;SM left the SS unattended in the car for three minutes.LE confirmed this via surveillance footage.SM said she then stopped at a friend's house, did not get out of the vehicle.SM did not recall what time she and the CHN arrived home, but upon arriving, she fixed SC a bottle and put him in his rocker.SM said she put the rocker in stationary mode so it would not move, put a blanket on SC, and bunched the end of the blanket

into the corner of the rocker by SC's shoulder.SM propped SC's bottle using the blanket, and left SC unattended to go outside with the SS, and smoked a cigarette.SM said she was outside between 5 to 15 minutes.When SM returned inside, she found SC on his side with the blanket over his head, his face turned into the blanket.SC was blue and not breathing.SM began CPR and called 911.The older SS's biological father arrived home during this time, but it was not documented where the SS were.EMS arrived and transported SC to the hospital.

SM told CCDSS that she smoked marijuana daily, and had MH diagnoses that were untreated.SM denied she was impaired when the incident took place.SM said she regularly propped bottles for SC, and used bottles with altered nipples when she added oatmeal to the formula. CCDSS did not discuss altering bottle nipples with the pediatrician.

An SCR report made on 7/7/17 contained allegations unrelated to the death of SC.It alleged SM threw objects at the SS, lost her temper easily, and cursed at them.CCDSS consolidated this report into the fatality investigation and appropriately and thoroughly addressed the additional concerns.

Throughout the investigation, SM's account of events changed.Concerns were noted regarding SM's MH and drug use.SM planned to continue a relationship with BF, with whom she had a history of DV.CCDSS filed a Neglect Petition in Family Court on 7/20/17.A services case was opened.SM was ordered to engage in MH/substance abuse counseling and parenting classes.BF was incarcerated throughout the investigation for charges related to DV with another woman, not SM.At the time of this writing, the services case remained open, and the court proceedings remained ongoing.SM was compliant, and all the SS returned to her care on 7/30/17.

CCDSS made collateral contacts, including the ME, hospital, pediatrician, and EMS.Assessments were completed timely.CCDSS found evidence to Sub the allegations of IG and LS, but Unsub for DOA/Fatality due to lack of medical evidence.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical 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: This fatality investigation was conducted by the Chautauqua County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Chautauqua 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
042181 - Deceased Child, Male, 5 Mons	042182 - Mother, Female, 23 Year(s)	Lack of Supervision	Substantiated
042181 - Deceased Child, Male, 5 Mons	042182 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
042181 - Deceased Child, Male, 5 Mons	042182 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated

042185 - Sibling, Female, 6 Year(s)	042182 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
042186 - Sibling, Male, 4 Year(s)	042182 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
042187 - Sibling, Female, 1 Year(s)	042182 - Mother, Female, 23 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?	☐	☒	☐	☐
Caretakers / Babysitters	☐	☒	☐	☐
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:

CCDSS contacted an array of collateral sources to gather information surrounding the family and SC's death. The record did not reflect CCDSS contacted a babysitter that often watched the CHN.

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:
As a result of SC's death, the SS were placed with MGM, her husband, and MGGM due to concerns regarding SM's mental state and her ability to appropriately continue caring for the children. A plan was implemented where SM would not have unsupervised contact with the SS, nor would she spend overnights with them in MGM's home.

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:**

07/20/2017	There was not a fact finding	Adjourned
Respondent:	042182 Mother Female 23 Year(s)	
Comments:	An Article 10 Neglect Petition was filed against SM regarding the SS. BF was not named as a respondent on the petition, as he was incarcerated and remained so at the time of this writing. The SS were at first placed with maternal grandparents, and then the two older SS were placed with their biological father. SM was only allowed supervised visits with no overnights. SM was ordered to engage in mental health and substance abuse counseling, as well as parenting classes. Services were offered to the two oldest SS's biological father; however, he refused to cooperate. The SS were returned to SM's care on 7/31/17, with no restrictions. Court proceedings regarding the Neglect Petition remained ongoing at the time of this writing, and CCDSS continued to monitor.	

Have any Orders of Protection been issued? No

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:
A Neglect Petition was filed and SM was then court ordered to begin several services. Referrals were made for the SS to begin grief/MH services at the CCDSS CAC.

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 services case was opened in response to the fatality. CCDSS encouraged SM to have the children engage in grief/counseling services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief and trauma services were offered to the family. A court ordered services case was opened in response to the fatality. SM was ordered to begin an array of services, including MH counseling, parenting, and a substance abuse evaluation/counseling.

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

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)
03/12/2017	Sibling, Male, 4 Years	Other Adult - Two Older SS's BF, Male, 30 Years	Lack of Supervision	Unfounded	Yes
	Sibling, Male, 4 Years	Other Adult - OA's girlfriend , Female, 25 Years	Lack of Supervision	Unfounded	

Other Child - OA's girlfriend's child, Male, 5 Years	Other Adult - Two Older SS's BF, Male, 30 Years	Lack of Supervision	Unfounded
Other Child - OA's girlfriend's child, Male, 5 Years	Other Adult - OA's girlfriend , Female, 25 Years	Lack of Supervision	Unfounded
Other Child - OA's girlfriend's child, Male, 5 Years	Other Adult - OA's girlfriend , Female, 25 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 5 Years	Other Adult - Two Older SS's BF, Male, 30 Years	Lack of Supervision	Unfounded
Sibling, Female, 5 Years	Other Adult - OA's girlfriend , Female, 25 Years	Lack of Supervision	Unfounded
Sibling, Male, 4 Years	Other Adult - Two Older SS's BF, Male, 30 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 5 Years	Other Adult - OA's girlfriend , Female, 25 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 5 Years	Other Adult - Two Older SS's BF, Male, 30 Years	Inadequate Guardianship	Unfounded
Other Child - OA's girlfriend's child, Male, 5 Years	Other Adult - Two Older SS's BF, Male, 30 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 4 Years	Other Adult - OA's girlfriend , Female, 25 Years	Inadequate Guardianship	Unfounded

Report Summary:
This report was received with concerns that the two older SS's biological father's girlfriend's 6-year-old son touched the 5-year-old and 4-year-old SS inappropriately while on visitation with the two older SS's biological father. The report further alleged the two older SS's biological father and his girlfriend were not appropriately supervising the children, despite being aware of the inappropriate behaviors.

Determination: Unfounded | **Date of Determination:** 07/12/2017

Basis for Determination:
CCDSS completed home visits and interviews with all family members. Collateral contacts were made, and concerns were addressed with the family as they arose. CCDSS noted the two older SS's biological father and his girlfriend denied the allegations in the report. CCDSS also stated the children made no disclosures surrounding the allegations. CCDSS unfounded and closed the investigation.

OCFS Review Results:
The 7-Day Safety assessment was nearly two months late and did not address the alleged concerns. Although CCDSS documented safe sleep provisions were observed for all children, the record did not reflect that CCDSS educated the parents surrounding safe sleep practices. Several progress notes were entered months after the event dates. Notices of Existence were not mailed/delivered timely. The interviews with the children did not elicit any information surrounding what was alleged, including questions regarding inappropriate touching. CCDSS did not offer the family services.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
CCDSS completed the 7-Day Assessment; however, it was nearly two months late. The safety factors alleged in the report were not addressed in the assessment. The nature of the concerns required that the children be supervised at all times until further investigation into the allegations. The assessment only spoke of home cleanliness and not of the possible sexual acting out between the children.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
CCDSS will complete Safety Assessments within required time frames, and provide a comprehensive assessment of all safety factors present at the time of the assessment.

Issue:
Failure to provide safe sleep education/information
Summary:
Although CCDSS documented observing safe sleep provisions for all of the children in the households, the record does not reflect that CCDSS educated the parents surrounding safe sleep practices.
Legal Reference:
13-OCFS-ADM-02
Action:
CCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be, and if needed, will assist families in obtaining appropriate sleep provisions for the child(ren).

Issue:
Adequacy of Progress Notes
Summary:
Several notes were entered into Connections months after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
CCDSS will enter progress notes contemporaneously as events occur.

Issue:
Adequacy of face-to-face contacts with the child and/or childs parents or guardians
Summary:
CCDSS interviewed each of the verbal children separately; however, the CW did not address the allegations in the report. The interviews did not elicit any information surrounding what was alleged, including questions regarding inappropriate touching.
Legal Reference:
432.1 (o)
Action:
CCDSS will adequately interview all children on a report and fully address the allegations.

Issue:
Review of CPS History
Summary:
CCDSS did not document a review of CPS history.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within five business days of the oral report date, CCDSS will review its own CPS record(s) that apply to the prior reports, including legally unfounded and family assessment response reports.

Issue:
Predetermination/Assessment of Current Safety and Risk
Summary:

CCDSS noted in the investigation conclusion the reasons for unsubstantiating the allegations were due to the parents' denial and no disclosures from the children; however, CCDSS did not fully explore the allegations with the children and therefore could not adequately determine safety/risk or any truth to the concerns.

Legal Reference:

18 NYCRR 432.1(aa)

Action:

CCDSS will fully explore the safety and risk of all children in households prior to determining a report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/17/2017	Sibling, Female, 6 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unfounded	Yes
	Deceased Child, Male, 1 Days	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 5 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Female, 2 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:

This report was received with concerns SM gave birth to SC and was positive for marijuana.

Determination: Unfounded | **Date of Determination:** 03/14/2017

Basis for Determination:

CCDSS conducted interviews with SM and multiple home visits to assess the safety of the children. Safe sleep was observed and discussed. CCDSS followed up with the children's pediatrician and no concerns were noted. SC's toxicology results also came back positive for marijuana, and CCDSS smelled marijuana during a home visit and also observed drug paraphernalia. CCDSS encouraged SM to attend MH counseling. CCDSS attempted to make contact with the two older SS's biological father, but was unsuccessful.

OCFS Review Results:

Connections reflects this report was unfounded; however, CCDSS clearly documented in the Investigation Conclusion that the report was to be indicated. CCDSS did not adequately interview the verbal SS. The case record did not reflect if unfounded CPS history was reviewed. CCDSS made no attempts to have BF interviewed.

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:

CCDSS did not adequately interview the verbal SS. CCDSS did not ask them if they saw SM using marijuana, or if they had any knowledge of such. Further, the SS expressed SM spanked them but CCDSS did not explore this further. CCDSS did not make any attempts to have BF interviewed in jail.

Legal Reference:

432.1 (o)

Action:

CCDSS will adequately interview all individuals listed on a report, including children.

Issue:

Review of CPS History

Summary:

CCDSS documented indicated history for the family; however, it was not documented whether or not unfounded history was reviewed.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

Within five business days of the oral report date, CCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/31/2015	Sibling, Female, 1 Days	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unfounded	Yes
	Sibling, Female, 1 Days	Mother, Female, 22 Years	Inadequate Guardianship	Unfounded	

Report Summary:

This report was received with concerns SM gave birth to then newborn SS, and was positive for marijuana.

Determination: Unfounded | **Date of Determination:** 10/15/2015

Basis for Determination:

CCDSS interviewed SM and the two older SS's biological father regarding the allegations in the report.CCDSS assessed the home environments, observed safe sleep provisions, and noted no concerns.The SS were all observed and appeared healthy and safe.Two toxicology results for the newborn SS were received;one was positive for marijuana and one was negative.There was nothing in the case record to indicate if there was a reason for this.CCDSS followed up with the SS's pediatrician and hospital staff where the SS was born.CCDSS noted the positive toxicology had no negative or lasting affects on the newborn SC.CCDSS offered services, which were declined, and UNF and closed the case.

OCFS Review Results:

CCDSS did not send all Notices of Existence or review CPS history within the required time frames. CCDSS did not fully interview, or attempt to interview the verbal SS.

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

Issue:

Review of CPS History

Summary:

CCDSS did not review CPS history within the required time frame. CCDSS did not document if unfounded CPS history was reviewed.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

Within five business days of the oral report date, CCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:

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

Summary:

CCDSS did not interview, or attempt to interview, the verbal SS regarding the allegations in the report, or general safety.

Legal Reference:

432.1 (o)

Action:

CCDSS will interview, or attempt to interview, all children in a household.

Issue:
Failure to provide notice of report
Summary:
CCDSS did not mail or deliver all Notices of Existence withing the required 7-day time frame.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
CCDSS will notify the subjects and other persons named in areport, except children under the age of 18 years, in writing, no later than seven days after receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/22/2015	Sibling, Female, 3 Years	Father, Male, 21 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 2 Years	Father, Male, 21 Years	Inadequate Guardianship	Unfounded	

Report Summary:
This report was received with concerns BF was physically assaulting SM in the presence of the then 3 and 2 year old SS.

Determination: Unfounded | **Date of Determination:** 03/07/2015

Basis for Determination:
CCDSS found that both SM and BF admitted to engaging in a domestic violence incident which caused injury to SM. CCDSS based their determination on interviews with SM and BF, where each said the SS were not present during the incident. CCDSS completed home visits and found no safety concerns. CCDSS observed and interacted with the SS and assessed them to be safe. CCDSS felt they did not have enough evidence to substantiate the allegations.

OCFS Review Results:
CCDSS did not adequately interview all individuals. SM and BF reported SS were not present during the DV incident, but CCDSS never asked where the SS were at the time. One SS reported BF choked SM many times, but CCDSS never asked for any other details. CCDSS did not meet with BF face to face. CCDSS did not follow up with pertinent collateral contacts. All allegations were not explored. CPS history review was not completed timely. The final determination was not appropriate.

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:
CCDSS did not conduct adequate interviews.Although SM and BF reported the SS were not present during the DV incident,CCDSS never asked where the SS were.The oldest SS reported BF choked SM many times and it scared her,but CCDSS never asked if she saw this happen, or any other details. Safety was not discussed with the SS. The two older SS's biological father was never fully interviewed.
Legal Reference:
432.1 (o)
Action:
CCDSS will adequately interview all individuals listed on a report, including children.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
CCDSS did not interview BF face to face.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
CCDSS did not follow up with any pertinent collateral contacts SM and BF claimed to be involved with (DV, anger management). CCDSS did not follow up with LE to obtain incident reports. CCDSS did not contact the SS's pediatrician.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
CCDSS will contact all appropriate collateral sources during an investigation.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
CCDSS did not ask safety or risk-related questions of the SS, nor adequately assess the extent of the SS's exposure to DV.It was reported that BF of SC tossed the SS (not BF's child) on a couch and he fell, causing a bruise.CCDSS did not explore this further. CCDSS did not follow up on allegations that SS were acting out due to witnessing DV.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
CCDSS will fully explore all allegations and other concerns as they arise prior to determining a report.

Issue:
Review of CPS History
Summary:
CCDSS did not document a CPS history review within the required time frame. CCDSS did not document if unfounded CPS history was reviewed.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within five business days of the oral report date, CCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Appropriateness of allegation determination
Summary:
Although SM and BF reported the SS were not present during the DV incident, the oldest SS reported BF choked SM on more than one occasion and this scared her. DV that occurs in front of children places said children at imminent risk of harm, and therefore, some credible evidence was available to substantiate the allegation of IG.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
CCDSS has the responsibility for making a determination as to whether there is some credible evidence of child abuse and/or maltreatment so as either to indicate or unfound a report of child abuse and/or maltreatment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/23/2014	Sibling, Female, 3 Years	Grandparent, Male, 42 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 2 Years	Grandparent, Male, 42 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 3 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 2 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unfounded	

Report Summary:
This report was received with concerns SM chased the then 4 and 2 year old SS, and beat them. Further, the report alleged the two older SS's biological father and SM were involved in a physical altercation that was witnessed by the SS. It was reported SM smoked marijuana regularly and had drug paraphernalia within the SS' reach.

Determination: Unfounded **Date of Determination:** 01/13/2015

Basis for Determination:
CCDSS interviewed SM, the two older SS's biological father, and MGF regarding the allegations in the report. CCDSS discovered SM and MGF were involved in a verbal and physical altercation in front of the SS, but the SS were not harmed during the event and it was an isolated incident. All homes were observed and assessed to be safe; no drug paraphernalia was seen and SM seemed sober and coherent at all visits. The oldest SS was interviewed and reported no concerns, and the youngest SS was observed and assessed as safe. CCDSS followed up with collateral contacts; no concerns were expressed.

OCFS Review Results:
The investigation addressed all allegations appropriately; however, CCDSS did not offer the family services, and did not inquire as to how old MGF's children were, observe them, or attempt to interview them.

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

Issue:
Failure to Offer Services
Summary:
CCDSS did not offer the family any available services prior to closing the investigation.
Legal Reference:
SSL 424(10); NYCRR 428.6
Action:
CCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
Although MGF was listed as a subject on the report, CCDSS did not inquire as to how old MGF's children were that resided in his home, nor did they observe/interview the children, or assess their safety/risk.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
CCDSS will assess the safety and risk of all children in households of those named on a report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/12/2014	Sibling, Female, 3 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 3 Years	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 1 Years	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 1 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unfounded	

Report Summary:
This report was received with concerns SM and her roommate were selling drugs from their home and using drugs around the then 3 and 1 year old SS. Further, it was alleged the drugs were accessible to the SS, and on 8/21/14, police performed a drug raid on the home. The two older SS's biological father's role was unknown.

Determination: Unfounded | **Date of Determination:** 10/03/2014

Basis for Determination:
CCDSS based their determination on interviews with SM and the two older SS's biological father, home visits, and collateral contacts. The SS were observed to be healthy and safe. CCDSS did not observe any drug paraphernalia in the home, nor did they receive any information from police that would corroborate the allegations in the report.

OCFS Review Results:
The investigation met all statutory requirements. The CPS history check was documented late.

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

Issue:
Review of CPS History

Summary:
CCDSS did not review CPS history within the required time period. CCDSS did not document if unfounded history was reviewed.

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

Action:
Within five business days of the oral report date, CCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Failure to Offer Services

Summary:
CCDSS did not offer the family any available services prior to closing the investigation.

Legal Reference:
SSL 424(10); NYCRR 428.6

Action:
CCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

11/8/13: SM was indicated for IG, LS, P/Nx regarding the two oldest SS.

There is no additional CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

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

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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