Child Fatality Report

Report Identification Number: BU-17-029

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

Issue Date: Apr 19, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 04/28/2013
Initial Date OCFS Notified: 10/19/2017

Presenting Information

A 7065 Reporting Form was submitted which stated on 4/28/13, the infant (SC) died due to complications from underlying medical conditions. The infant's death occurred during an open CPS investigation.

Executive Summary

This fatality report concerns the death of a one-month-old male infant (SC) that occurred on 4/28/13. The infant died during an open CPS investigation that was received by Niagara County Department of Social Services (NCDSS) with concerns unrelated to the fatality. A completed 7065 Report Form was not completed and sent to OCFS until 10/19/17. A Death Certificate received on 12/17/17 noted the manner of death as “Natural.”

At the time of the infant's death, NCDSS was investigating an SCR report that was received on 3/28/13 which had allegations against the mother in relation to the infant child, unrelated to the fatality. The infant resided with his mother (BM) at the time of his death, and the mother had another child, a 3-year-old female (SS), who was in the legal custody of her maternal grandmother (MGM). On 4/12/13, NCDSS received a phone call from the maternal grandmother that the infant had turned blue and stopped breathing while in the mother’s care over that weekend. The grandmother informed NCDSS that the infant needed emergency surgery due to an underlying medical condition, and would stay in the hospital until recovered. On 4/30/13, the maternal grandmother again called NCDSS and informed them the infant passed away on 4/28/13 due to complications from the surgery.

Although the maternal grandmother reported the infant died from a genetic heart and liver abnormality, NCDSS did not follow up with any collateral sources, the mother, or the father regarding the death of the infant, and there were no further details gathered surrounding the infant’s death, or the events leading up to it. NCDSS closed their investigation on 5/7/13.

PIP Requirement
NCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) NCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, NCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A

- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
This fatality was not SCR reported and therefore there were no allegations surrounding SC's death.

Was the decision to close the case appropriate? No

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:
NCDSS did not assess SS's home environment for safety, nor interview her. NCDSS did not adequately explore SC's death prior to case closure.

Required Actions Related to the Fatality

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

Issue:	Failure to report death of child in open CPS or Preventive/CPS services case in timely manner
Summary:	NCDSS did not notify OCFS of SC's death until 10/12/17, and did not submit a completed 7065 form until 10/19/17.
Legal Reference:	06-OCFS-LCM-13
Action:	NCDSS is required to provide telephone notice to the Regional Office within 24 hours of learning of the death of a child in an open CPS or preventive services case. Within 72 hours of the death, NCDSS must complete a copy of the 7065 Form and e-mail or fax it to the Regional Office, and to any approved local or regional fatality review team that will review the fatality.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/28/2013 **Time of Death:** 10:28 PM

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

County where fatality incident occurred: Niagara
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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: Hospitalized

Did child have supervision at time of incident leading to death? Unable to determine

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	No Role	Male	1 Month(s)
Deceased Child's Household	Mother	No Role	Female	20 Year(s)
Other Household 1	Father	No Role	Male	20 Year(s)

LDSS Response

On 10/19/17, NCDSS submitted a completed 7065 Reporting Form to OCFS regarding the death of SC, which occurred on 4/28/13. At the time of SC's death, there was an ongoing CPS investigation, which began on 3/28/13. This investigation was surrounding concerns BM tested positive for drugs upon delivery of SC on that same date, but this report was not related to SC's death. It was determined SC did not test positive for drugs, and was therefore released to BM from the hospital. On 4/12/13, NCDSS was informed by MGM that over that weekend, SC "turned blue and had trouble breathing" while in BM's care, and EMS was called. MGM informed NCDSS that SC was transported to the hospital, where he underwent invasive surgery, as the doctors found a congenital issue that needed repair. At the time NCDSS spoke with MGM, SC was recovering from the surgery in the hospital. NCDSS did not reach out to BM or BF upon learning this information; however, on 4/30/13, NCDSS received a phone message from MGM that SC had passed away on 4/28/13 due to complications from surgery.

In response to SC's death, NCDSS attempted to make an SCR report, but the report was not accepted as NCDSS had no concerns the fatality was due to abuse or maltreatment. It is unclear in the case record how NCDSS determined this, as there are no documented attempts to speak with the hospital staff that cared for SC, inquire if an autopsy was completed, nor speak with BM, BF or any other collateral sources surrounding SC's death. NCDSS did not offer any services to the family, and noted BM's positive toxicology at SC's birth did not in any way contribute to his death; however, the case record does not reflect how NCDSS obtained this information.

NCDSS was able to observe the SS at SC's funeral on 5/3/13, and noted she appeared "healthy and very well cared for." NCDSS unsubstantiated the allegations in the SCR report, and closed their investigation on 5/7/13.

On 12/1/17, per OCFS' request, NCDSS obtained a copy of the Death Certificate, which noted the manner of death as "Natural", and the immediate cause as "Respiratory Failure" due to, or as a consequence of, "Parainfluenza Pneumonia." The 7065 form reflected NCDSS referred the family to Medicaid for funeral assistance.

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: Hospital physician

Multidisciplinary Investigation/Review

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

Comments: The record does not reflect if the fatality was reviewed by the Niagara County Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☒	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

NCDSS did not gather sufficient details surrounding the events leading up to SC's death, such as who was present and what SC was doing when found not breathing. BF was not spoken to, nor was hospital staff where SC was cared for.

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?				
Explain: NCDSS observed the SS at SC's funeral, but did not interview her or make attempts to assess her home environment prior to closing the investigation.				

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?	☐	☒	☐	☐
Explain as necessary: The SS was in the care and custody of MGM at the time of SC's death. NCDSS did not adequately assess her safety or interview her upon learning of SC's passing.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral

Bereavement counseling	☐	☐	☐	☒	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☒	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☒	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
NCDSS did not offer the family appropriate services in response to SC's death or otherwise, prior to closing the initial CPS investigation. It was later found via the 7065 Reporting Form, received in October 2017, that NCDSS did refer the family to Medicaid for assistance with funeral costs; this was not documented in the case record at the time of the investigation.

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? No
Explain:
The family's needs were not appropriately assessed, as there are no documented attempts to meet with the family after learning of SC's death. A referral had been made for the family to obtain funeral assistance via Medicaid, but no other services were offered.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The family's needs were not appropriately assessed, as there are no documented attempts to meet with the family after learning of SC's death. A referral had been made for the family to obtain funeral assistance via Medicaid, but no other services were offered.

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?	Yes
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)
03/28/2013	Deceased Child, Male, 1 Months	Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unfounded	Yes

Report Summary:
This report was received with concerns BM gave birth to SC and BM tested positive for marijuana. BF had an unknown role.

Determination: Unfounded | **Date of Determination:** 04/30/2013

Basis for Determination:
NCDSS interviewed BM and MGM regarding the concerns. NCDSS spoke with hospital staff who confirmed SC did not test positive for marijuana and was not showing any signs of withdrawal. NCDSS completed home visits to assess safety of the home and SC, and educated BM surrounding safe sleep practices. SC passed away from natural causes during this investigation. NCDSS attempted to make an SCR report regarding the death but it was not accepted. NCDSS gathered information from BM and MGM surrounding SC's death and determined it was not suspicious. NCDSS unfounded and closed the case.

OCFS Review Results:
NCDSS did not interview BF, or make any attempts to do so. Services were not offered to the family prior to case closure. Sufficient information was not gathered surrounding SC's death, and NCDSS did not follow up with hospital staff regarding the cause of the death. The CPS history check was completed a day late.

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

Issue:
Failure to Offer Services

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

Legal Reference:
SSL 424(10); NYCRR 428.6
Action:
NCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
NCDSS determined the investigation without fully looking into SC's death. The determination noted SC's death was not attributed to the BM's drug use, but it is unclear where NCDSS obtained this information. It was also noted in the determination that SC had a birth defect, which ultimately caused his death, but this was not appropriately explored or confirmed during the investigation.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
Prior to making a determination of a report of abuse and/or maltreatment, the investigation conducted by the child protective service shall include a determination of the nature, extent and cause of any condition enumerated in the report.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
NCDSS did not follow up with the hospital staff that treated SC, the ME/coroner, or first responders.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
NCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Adequacy of face-to-face contacts with the child and/or childs parents or guardians
Summary:
NCDSS did not document any attempts to interview SC's BF.
Legal Reference:
432.1 (o)
Action:
NCDSS will make reasonable efforts to make casework contacts with biological parents and/or other persons named in a report. Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians.

Issue:
Review of CPS History
Summary:
The CPS history check was completed one day late.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, NCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child’s sibling, and, for indicated

reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/05/2013	Sibling, Female, 2 Years	Other Adult - MGM's Significant Other (MSGF), Male, 40 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 2 Years	Other Adult - MGM's Significant Other (MSGF), Male, 40 Years	Sexual Abuse	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 2 Years	Mother, Female, 20 Years	Sexual Abuse	Unfounded	
	Sibling, Female, 2 Years	Grandparent, Female, 39 Years	Sexual Abuse	Unfounded	
	Sibling, Female, 2 Years	Mother, Female, 20 Years	Inadequate Guardianship	Unfounded	

Report Summary:
This report was received with concerns the then 2 yo SS had sexual knowledge beyond her years, and was acting out sexually. Further, the report alleged BM, MGM, and maternal step-grandfather (MSGF) allowed SS to touch MSGF in a sexual manner, and failed to address the matter.

Determination: Unfounded | **Date of Determination:** 03/21/2013

Basis for Determination:
NCDSS interviewed MGM and BM; MSGF was present during the interview with MGM, but the case record does not reflect any conversation with him regarding the allegations. NCDSS had SS examined at the CAC and no concerns were noted. NCDSS obtained records from the pediatrician and noted “no major concerns”. The home environment was assessed as safe. SS was too young to be interviewed. NCDSS unfounded and closed the report.

OCFS Review Results:
NCDSS did not document BM’s CPS history was reviewed. NCDSS did not add the 12 yo and 17 yo siblings, who lived in the household, to the report, nor were they interviewed. NCDSS did not appropriately address concerns regarding the 17 yo sibling. Services were not offered prior to case closure. Collateral contacts were insufficient.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The record did not reflect if NCDSS spoke with the pediatrician to confirm SS had medical conditions that may have contributed to what appeared to be sexual behaviors. NCDSS did not contact the 17 yo sibling's MH provider after learning of concerns.

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

Action:
NCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Review of CPS History

Summary:
The record does not reflect if BM's CPS history was reviewed, only that of MGM and MSGF.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, NCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child's sibling, and, for indicated reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.

Issue:
Predetermination/Assessment of Current Safety and Risk
Summary:
NCDSS did not interview the two minor siblings who resided in the home, nor adequately assess their safety or future risk of abuse/maltreatment.
Legal Reference:
18 NYCRR 432.1(aa)
Action:
Prior to making a determination, NCDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
Throughout the investigation, NCDSS learned the 17 yo SS was using drugs with MSGF, as well as other concerns regarding this child. NCDSS did not appropriately address the concerns that arose prior to closing their investigation.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
Prior to making a determination of a report of abuse and/or maltreatment, the investigation conducted by the child protective service shall include a determination of the nature, extent and cause of any condition enumerated in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/20/2012	Other Child - BM's Sibling, Female, 16 Years	Mother, Female, 19 Years	Childs Drug / Alcohol Use	Indicated	Yes
	Other Child - BM's Sibling, Female, 16 Years	Mother, Female, 19 Years	Inadequate Guardianship	Indicated	

Other Child - BM's Sibling, Male, 11 Years	Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 2 Years	Mother, Female, 19 Years	Inadequate Guardianship	Indicated
Sibling, Female, 2 Years	Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Indicated
Other Child - BM's Sibling, Male, 11 Years	Mother, Female, 19 Years	Inadequate Guardianship	Indicated
Other Child - BM's Sibling, Female, 16 Years	Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Indicated

Report Summary:
This report was received with concerns BM was using drugs and alcohol to intoxication, and engaged in physical confrontations around the then 2-year-old SS and BM's 16 and 11-year-old siblings.

Determination: Indicated **Date of Determination:** 06/08/2012

Basis for Determination:
NCDSS based their determination on limited interviews with MGM, MSGF. BM's siblings were briefly spoken to, and collateral contacts to the pediatrician and youngest sibling's school were made. NCDSS observed the SS and home environment and noted no concerns. NCDSS made one attempt to interview BM, via phone call. BM returned the call to CW and refused to speak or meet with CW.

OCFS Review Results:
The RAP was inaccurate. NCDSS did not make any attempts to meet with BM face to face. All appropriate collateral sources were not contacted, including LE, the older sibling's school, and BM's previous MH providers who could speak to BM's non-compliance and possible drug use. The BFs of all children in the household were not added, notified, or interviewed. There was no casework activity between 4/3/12 and 6/4/12. The interview with the older sibling was not adequate, as safety nor anything specific to the allegations was discussed.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
RAP questions were not explored with MGM or MSGF. Question #2 regarding any child in the care/custody of other caregivers was marked "No", but should have been "Yes", as MGM had custody of SS. Question #7, regarding victim/perpetrator of abusive or threatening incidents was checked "No", but should have been "Yes".

Legal Reference:
18 NYCRR 432.2(d)

Action:
NCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Face-to-Face Interview (Subject/Family)

Summary:
NCDSS did not document any attempts interview BM face to face.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:
The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Issue:
Adequacy of face-to-face contacts with the child and/or childs parents or guardians
Summary:
NCDSS did not identify who the BF of the female sibling was, nor make any attempts to interview him. NCDSS did not make any attempts to interview SS's BF. NCDSS did not address safety during interviews with the female sibling, nor did they adequately address allegations with either verbal child in the home.
Legal Reference:
432.1 (o)
Action:
NCDSS will make reasonable efforts to interview all persons named in a report, face to face, who may have been present during what was alleged in the report, and/or may have information pertinent to the safety and well-being of children that reside in the home, including absent biological parents.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
All appropriate collateral sources were not contacted, including LE, the older sibling's school, and BM's previous MH providers who could speak to BM's non-compliance and possible drug use.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
NCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Failure to provide notice of report
Summary:
The BFs of the female sibling and SS were not added to the report or notified of the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
NCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/05/2010	Sibling, Female, 3 Months	Father, Male, 19 Years	Lack of Supervision	Indicated	Yes
	Sibling, Female, 3 Months	Mother, Female, 17 Years	Lack of Supervision	Indicated	
	Sibling, Female, 3 Months	Father, Male, 19 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 3 Months	Mother, Female, 17 Years	Inadequate Guardianship	Indicated	

Report Summary:
This report was received with concerns BM left then 3-month-old SS alone in the home unsupervised, and failed to tell PGF or BF that she was leaving. As a result, SS fell out of her infant chair and was subsequently choked by a strap that was attached to the chair. PGF went into the room after hearing SS crying; SS was uninjured.

Determination: Indicated | **Date of Determination:** 06/14/2010

Basis for Determination:
NCDSS completed home visits and interviews with family members, and followed up with LE regarding the incident.

NCDSS found the allegations in the report narrative to be true; BM did leave the home without informing PGF or BF that SS was alone and in her infant chair. NCDSS ultimately removed the SS from BM and BF's custody, and filed a petition in Family Court. NCDSS indicated the report and opened the case for services.

OCFS Review Results:
NCDSS did not contact all appropriate collaterals, including SS's pediatrician, EMS, and MH providers to address if BM had serious MH concerns, as reported by family members. NCDSS requested incident reports from LE, but never followed up to obtain them. There was a concern regarding possible domestic violence between PGF and BM, but NCDSS did not explore this further. There were further concerns SS had an ear infection and SM failed to bring her to the pediatrician. NCDSS did not follow up about this concern. The RAP was completed inaccurately. A CPS history check was not completed.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
NCDSS did not adequately address potential concerns that could pose safety/risk issues, including BM's possible MH issues, alleged domestic violence between BF and PGF, and BM failing to have SS treated for an ear infection in a timely manner.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
Prior to making a determination of a report of abuse and/or maltreatment, the investigation conducted by the child protective service shall include a determination of the nature, extent and cause of any condition enumerated in the report.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
NCDSS did not follow-up with all appropriate collaterals, including EMS, SS's pediatrician, LE regarding incident reports, and BM's past MH provider.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
NCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
NCDSS did not accurately complete the RAP. The question surrounding abusive or threatening incidents with partners or other adults should have been "yes" regarding BM. The question asking if caretaker demonstrated developmentally appropriate expectations of all children should have been "no" regarding BM. A secondary caretaker was not added to the RAP; however, BF lived in the home.
Legal Reference:
18 NYCRR 432.2(d)
Action:
NCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Review of CPS History

Summary:
NCDSS did not complete a CPS history check on any of the household members.

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

Action:
Within 1 business day of a report, NCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child's sibling, and, for indicated reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/09/2010	Sibling, Female, 2 Months	Mother, Female, 17 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 2 Months	Mother, Female, 17 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 2 Months	Mother, Female, 17 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:
This report was received with concerns on 5/8/10, BM left SS unsupervised while she was out using drugs, and when she returned home, struck the then 2-month-old SS in the face; no visible injuries resulted. Further concerns were that BM had no patience with SS, and had a history of drug use.

Determination: Unfounded | **Date of Determination:** 05/20/2010

Basis for Determination:
NCDSS based their determination on one home visit, where BM denied the allegations in the report, and the CW observed SS to be free from any visible marks/injuries.

OCFS Review Results:
NCDSS did not complete an adequate investigation. There were no collateral contacts, services were not offered to the family, CPS history checks were not completed, the BF and MGM were not adequately interviewed, the paternal grandparents were not added to the case, even though BM, BF, and SS resided in their home. The allegations in the report were only minimally explored, and the RAP was completed inaccurately. This report had similar allegations to a report that was received on 4/5/10, which was also not investigated fully or adequately.

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

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

Summary:
NCDSS closed the case without adequately exploring the allegations in the report, and other concerns as they arose. NCDSS did not ask specific questions regarding drug use, discipline, nor ask for any further information about the conflict between BM and her neighbor.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
Prior to making a determination of a report of abuse and/or maltreatment, the investigation conducted by the child protective service shall include a determination of the nature, extent and cause of any condition enumerated in the report.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

NCDSS did not contact any collaterals. Relevant collateral contacts would have included the SS pediatrician, BM's neighbor, and LE.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

NCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP was completed inaccurately. Questions surrounding MH and conflicts with family members/other adults should have been marked "yes" for BM. RAP questions were never explored with BF, who was listed at the secondary caretaker.

Legal Reference:

18 NYCRR 432.2(d)

Action:

NCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:

Failure to Offer Services

Summary:

NCDSS did not explore possible service needs the family may have, nor did they offer any appropriate or available services.

Legal Reference:

SSL 424(10); NYCRR 428.6

Action:

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

Issue:

Review of CPS History

Summary:

NCDSS did not complete a CPS history check for all household members.

Legal Reference:

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

Action:

Within 1 business day of a report, NCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child’s sibling, and, for indicated reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.

Issue:

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

Summary:

NCDSS did not fully or adequately interview SM, SF, or the grandparents, who also lived at the case address. Discussions surrounding drug use, mental health, discipline, home cleanliness concerns, conflicts with neighbors, supervision or any other concerns should have taken place.

Legal Reference:
432.1 (o)
Action:
NCDSS will conduct full and adequate interviews with subjects and other household members.

[redacted]

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

4/5/2010: UNF against BM and SS's BF for IG, PD/AM, and LM regarding SS.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Preventive Services History

A CPS services case was opened on 6/5/10 and a Neglect Petition was filed against BM and BF, after the then 3-month-old SS was left unsupervised in the home for an unknown period of time; BM was arrested and charged with Endangering the Welfare of a Child. There were no charges against BF, as he reported he was unaware BM left the home on the date of the incident. MGM was granted temporary custody of SS, with supervised visitation only for BM and BF. The court ordered an array of services for both parents (including MH, parenting classes, and substance abuse evaluations); neither parent complied. MGM obtained V Docket custody of SS on 10/18/10, and NCDSS dropped the Neglect Petition. The services case was closed on 11/30/10. SS remained in the care and custody of MGM at the time of the fatality. The RAP was inaccurate in this services case, and there was limited documentation regarding contact with BF regarding his service plan goals and input throughout the life of the case.

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?	☐	☐	☒	☐

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:**

06/08/2010	There was not a fact finding	CustodyGuardianship assigned to relative or non-relative (Article 6 non-foster care)
Respondent:	044962 Mother Female 20 Year(s)	
Comments:		

Additional Local District Comments

"As we discussed on the phone I don't believe this should be classified as a fatality report as an attempt to register it with the SCR was made and rejected.

The issues listed below would be, in my opinion, just good caseworker practice, fatality nonwithstanding.

1. Services should have been offered to the family
2. A death certificate should have been obtained on the child and the hospital contacted about the death
3. The BF should have been contacted
4. The history should have been reviewed in a timely manner"

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