Child Fatality Report

Report Identification Number: BU-17-030

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: 2 month(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 10/26/2017
Initial Date OCFS Notified: 10/26/2017

Presenting Information

An SCR report was received which alleged on the morning of 10/26/17, the mother and father had been co-sleeping with the infant child in their adult bed. When the parents awoke, the infant, who was an otherwise healthy child, was found unresponsive. The infant was then transported to the hospital where he was pronounced deceased.

Executive Summary

This fatality report concerns the death of a 2-month-old male infant (SC) that occurred on 10/26/17. A report was made to the SCR on that same date, with allegations of DOA/Fatality and IG against the infant's mother (SM) and father (SF). Niagara County Department of Social Services (NCDSS) conducted a thorough investigation into the infant's death. An autopsy was performed, but the results were not yet released at the time of this writing; however, the medical examiner reported the pending cause of death as "positional asphyxia."

This fatality report was subsequent to an initial report received on 7/21/17, with concerns regarding SM exhibiting violent and derogatory behavior toward her 1 and 6-year-old sons. The infant was born during this open investigation on 8/4/17, and both he and his mother tested positive for marijuana after his birth. At the time of discharge, the infant was deemed healthy with no ongoing medical concerns, and was released from the hospital into the care of his mother and father. The infant resided with his mother, father, and two surviving siblings. The 1-year-old sibling shared the same father as the infant, and the 6-year-old's biological father was incarcerated. On the day of the incident, a family friend (OA) had been visiting and stayed the night. The parents reported on the day of the infant's death, they had been co-sleeping with the child in their full-size bed. Both parents stated they were educated surrounding safe sleep practices, and had appropriate sleeping provisions in the home, but it was routine for the infant to bed share with them. The mother and father awoke for work the morning of 10/26/17 at approximately 5:30AM and found the infant unresponsive in the bed with blood coming from his nose. EMS was called and responded to the home, then transported the infant to a nearby hospital where he was pronounced deceased at 6:18AM.

From the time the investigation began to the time of its closure, NCDSS met with and interviewed family members, assessed home environments, followed up with numerous collateral sources, and offered appropriate services to the family. During NCDSS' involvement, immediate safety concerns arose regarding the infant's siblings and were addressed appropriately and promptly by NCDSS. An Abuse Petition was filed in Family Court against the mother and father due to concerns surrounding their ongoing alcohol/drug use and excessive corporal punishment in relation to the children. As a result, the siblings were removed and placed with their maternal grandmother. NCDSS substantiated the allegations in the report due to finding a causal link between the infant's death and his sleeping environment. At the time of this writing, Family Court proceedings remained ongoing, and a CPS services case was opened.

PIP Requirement

NCDSS and Erie County Department of Social Services (ECDSS) will each submit a PIP to their Regional Offices within 30 days of receipt of this report. The PIPs will identify action(s) they have taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, NCDSS and ECDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** 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:
At the time of case closure, NCDSS gathered sufficient information to assess the safety of the SS, as well as determine all of the allegations received in the report.

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

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

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

Explain:
NCDSS investigated the fatality thoroughly, as well as all other allegations as they arose. The casework was commensurate with the case circumstances, and there were detailed supervisory consultations throughout the case record.

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: 10/26/2017 **Time of Death:** 06:18 AM

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

Child Fatality Report

County where fatality incident occurred: Niagara
Was 911 or local emergency number called? Yes
Time of Call: 05:30 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	6 Year(s)
Other Household 1	Other Adult - BF of SS1	No Role	Male	30 Year(s)
Other Household 2	Other Adult - Half-SS's BM	No Role	Female	34 Year(s)
Other Household 2	Sibling	No Role	Male	9 Year(s)
Other Household 3	Grandparent	No Role	Female	49 Year(s)

LDSS Response

On 7/21/17, an SCR report was received with concerns SM was abusive toward the SS. SM gave birth to SC on 8/4/17 during the open investigation. A subsequent report was received due to SM and SC both testing positive for marijuana at the time of SC's birth. SC was not showing any negative impact due to the positive toxicology, and was therefore released to SM and SF from the hospital. SM's home was assessed and all necessary supplies were noted for SC. NCDSS spoke with SM and SF regarding the importance of a sober caretaker at all times.

On 10/26/17, NCDSS received another report regarding the death of SC. NCDSS initiated the fatality investigation within 24 hours and coordinated their efforts with LE. NCDSS spoke with hospital staff, EMS first responders, and the medical examiner to begin gathering information. A CPS history check was also completed for all individuals on the report.

On 10/26/17, NCDSS conducted a home visit to assess the safety of the SS. Through interviews with SM and SF, NCDSS

learned SC was born at home two weeks premature, but was assessed medically afterward and did not have any ongoing medical concerns. It was also discovered SM had regular prenatal care throughout her pregnancy, and the home was observed to have all appropriate provisions for the CHN, including two "Pack and Plays." The parents reported they were aware of the risks of an unsafe sleep environment and had been educated surrounding such, but did not regularly practice safe sleep with their CHN. Interviews revealed SC was placed to sleep with SM and SF in their full-size bed the night prior to his death: SF was on the outside, SM in the middle, and SC next to SM. SF reported he awoke the morning of 10/26/17 around 4:30AM to use the bathroom. He stated he returned to the bed and SC began crying so he gave him a pacifier, which soothed SC until he fell back to sleep. At approximately 5:30AM, both parents awoke. SM leaned over to tend to SC, and found him unresponsive with blood in his nose. OA heard commotion and went upstairs, and SF told OA to call 911. SM and SF started CPR on SC until LE arrived. EMS arrived shortly thereafter and transported SC to the hospital, where he was pronounced deceased.

On 10/26/17, NCDSS interviewed SS1 in school. He had no information surrounding SC's death. NCDSS established SS1's BF was incarcerated and had limited contact with SS1. NCDSS interviewed BF in prison; he reported no concerns regarding SS1 and had no information surrounding SC.

NCDSS discovered SC had a 9yo surviving half-sibling who resided with his BM. This CH was interviewed, as well as his BM. The child was assessed as safe and no concerns were noted.

Two more reports were received throughout the fatality investigation with concerns regarding SM and SF's substance use and violent behaviors toward the CHN. On 11/9/17, NCDSS discussed filing an Abuse/Neglect petition with their legal department. On 11/14/17, SS1 was observed by NCDSS to have a bruise under his eye; SS1 reported it was due to being hit by SM and SF and he was fearful being home. NCDSS worked with SM and SF to come up with a safety plan for the SS: both CHN would stay with MGM until further notice. NCDSS assessed MGM's home and interviewed all household members; no concerns were noted.

A petition was filed in Family Court on 11/16/17, and on 11/17/17 the SS were formally removed from and placed into the Article 10 custody of MGM; SM and SF were not allowed unsupervised around the CHN.

The medical examiner was consulted, and although the final autopsy results had not yet been released, the pending cause of death was "positional asphyxia". At the close of the investigation, the SS were deemed safe and no criminal charges were brought against either parent. NCDSS found evidence to Sub the allegations in the fatality report and indicated the investigation prior to opening for CPS services. At the time of this writing, the Family Court proceedings remained ongoing.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or 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 Niagara County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Niagara County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045141 - Deceased Child, Male, 2 Mons	045143 - Father, Male, 30 Year(s)	DOA / Fatality	Substantiated
045141 - Deceased Child, Male, 2 Mons	045142 - Mother, Female, 28 Year(s)	DOA / Fatality	Substantiated
045141 - Deceased Child, Male, 2 Mons	045143 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
045141 - Deceased Child, Male, 2 Mons	045142 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
045144 - Sibling, Male, 6 Year(s)	045143 - Father, Male, 30 Year(s)	Emotional Neglect	Substantiated
045144 - Sibling, Male, 6 Year(s)	045143 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
045144 - Sibling, Male, 6 Year(s)	045142 - Mother, Female, 28 Year(s)	Lacerations / Bruises / Welts	Substantiated
045144 - Sibling, Male, 6 Year(s)	045142 - Mother, Female, 28 Year(s)	Emotional Neglect	Substantiated
045144 - Sibling, Male, 6 Year(s)	045142 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
045144 - Sibling, Male, 6 Year(s)	045142 - Mother, Female, 28 Year(s)	Internal Injuries	Unsubstantiated
045145 - Sibling, Male, 1 Year(s)	045143 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
045145 - Sibling, Male, 1 Year(s)	045142 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
NCDSS spoke with all individuals named on the report, as well as an array of collateral sources. Progress notes were detailed and entered timely.

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:
During the course of the fatality investigation, SS1 and SS2 were removed and placed in the care and custody of MGM. An Abuse/Neglect Petition was filed in Family Court and the case was opened for CPS services. The 9 yo surviving half-sibling was deemed safe in the care of his mother.

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:**
11/16/2017	There was not a fact finding	Direct Custody Transferred toContinued with Relative (Article 10)
Respondent:	045142 Mother Female 28 Year(s)	
Comments:	During the course of the fatality investigation, an Abuse/Neglect Petition was filed against SM and SF on 11/16/17, regarding SS1 and SS2. Both SS were removed from SM and SF's care and placed in the Article 10 relative custody of MGM, with a permanency goal to prevent placement. The Family Court proceedings remained ongoing at the time of this writing.	

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: CPS Services Case

Additional information, if necessary:
NCDSS offered the family appropriate services in response to the fatality. The SS were removed from SM and SF's care, and placed with MGM; CPS services case was opened as a result.

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:
NCDSS offered a counseling referral for SS1, which was accepted by the parents.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
NCDSS offered the parents service referrals in response to SC's death; SM accepted but SF declined. A CPS services case was opened in response to the fatality, and both parents were court ordered to engage in services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? 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? 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 fetal alcohol effects or syndrome
☐ With neither of the issues listed noted in case record

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)
07/21/2017	Sibling, Male, 6 Years	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Indicated	Yes
	Deceased Child, Male, 14 Days	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 1 Years	Mother, Female, 28 Years	Inadequate Guardianship	Indicated	

Report Summary:
This report was received with concerns SM had an ongoing history of becoming enraged and physically/verbally violent toward her CHN. The report further alleged SM would hit SS1 using excessive force and had dragged him by his arms through rooms while screaming names at him. The SS's were fearful of SM and had suffered emotional distress as a result of her actions. It was unknown if the SS ever sustained any injuries. A subsequent report was received on 8/4/17 which alleged SC was born and SM tested positive for marijuana.

Determination: Indicated | **Date of Determination:** 04/03/2018

Basis for Determination:
NCDSS interviewed SM, SF, family members and collateral contacts surrounding the concerns. NCDSS spoke with SS1 and asked him about the allegations, which he initially denied. SC's toxicology was positive for marijuana at birth. While this investigation was open, SC died. Through this investigation, as well as the fatality investigation, NCDSS found evidence to substantiate the allegations. The investigation was indicated and opened for services.

OCFS Review Results:
Notice of Existence Letters were not mailed/delivered to the fathers of the CHN until 8/25. The majority of progress notes were entered several months after their event dates. NCDSS did not interview SS1 fully or away from his parents, despite this being the fourth report alleging physical violence toward him by SM and SF. There were no documented attempts to interview SS1's BF.

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

Issue:
Failure to provide notice of report
Summary:
Notice of Existence Letters were not mailed/delivered to the fathers of the CHN until 8/25/17.
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.

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 SS1's BF. The interview with SS1 regarding the initial concerns in the report was inadequate. NCDSS did not ask SS1 safety-related questions or inquire about any knowledge of alcohol/drug use in the home.

Legal Reference:

432.1 (o)

Action:

NCDSS will make 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:

Timely/Adequate Case Recording/Progress Notes

Summary:

The majority of progress notes were entered several months after their event dates.

Legal Reference:

18 NYCRR 428.5

Action:

NCDSS will enter progress notes contemporaneously as events occur.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/27/2017	Sibling, Male, 5 Years	Father, Male, 29 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 5 Years	Father, Male, 29 Years	Lacerations / Bruises / Welts	Unfounded	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:

This report was received with concerns SM and SF had a history of physical aggression toward SS1, which resulted in marks and bruises. There were concerns SS1 had been struck by a belt multiple times by SM, and that SF was physically abusive toward SM in the presence of the SS1; it was unknown if SS2 was present for the incident.

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

Basis for Determination:

NCDSS completed three home visits during the investigation. On the initial home visit, NCDSS asked SM and SF if the allegations were true and they denied. NCDSS asked SS1, who was standing on the stairs during the visit, if he had been hit with a belt and he said yes, and SM interjected and asked when, to which SS1 could not recall. NCDSS observed the home to be safe and the CHN free from marks and bruises. NCDSS followed up with the school and pediatrician, both of whom noted no concerns. NCDSS unsubstantiated the allegations and closed.

OCFS Review Results:

A Notice of Existence letter was not mailed/delivered to SS1's BF until 3/17/17. There were no documented attempts to meet with and/or interview BF. Most progress notes were entered one month or later after event dates. NCDSS did not make any attempts to adequately interview SS1, and merely asked him, in front of SM and SF, if he had ever been hit with a belt. NCDSS did not follow up with LE to obtain possible police reports regarding DV incidents in the home. NCDSS did not appropriately explore possible service needs, nor offer services to the family. The RAP was inaccurate.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The question regarding threatening/abusive incidents (#7) was answered "No" when it should have been "Yes," as past cases note SM had a history of DV relationships with SS1's BF and SF.

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:

Contact/Information From Reporting/Collateral Source

Summary:

NCDSS did not request police records despite allegations of DV and historical cases noting DV.

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:

Timely/Adequate Case Recording/Progress Notes

Summary:

Many progress notes were entered more than one month after their event dates.

Legal Reference:

18 NYCRR 428.5(a) and (c)

Action:

NCDSS will enter progress notes contemporaneously as events occur.

Issue:

Failure to provide notice of report

Summary:

A Notice of Existence Letter was not mailed/delivered to SS1's BF until 3/17/17.

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.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

NCDSS closed the investigation without adequately exploring the allegations in the report. There were no attempts to interview SS1 regarding the concerns or safety.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

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:

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

Summary:
There were no documented attempts to interview SS1's BF.
Legal Reference:
432.1 (o)
Action:
NCDSS will make 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/16/2016	Sibling, Male, 5 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Swelling / Dislocations / Sprains	Unfounded	
	Sibling, Male, 1 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Internal Injuries	Unfounded	
	Sibling, Male, 5 Years	Father, Male, 29 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 5 Years	Father, Male, 29 Years	Lacerations / Bruises / Welts	Unfounded	
	Sibling, Male, 1 Years	Father, Male, 29 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Excessive Corporal Punishment	Unfounded	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Lacerations / Bruises / Welts	Unfounded	
	Sibling, Male, 5 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Sibling, Male, 1 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 1 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:
This report was received with concerns SM and SF punched SS1 in the face, which caused a black eye. Three subsequent reports were received throughout this investigation with concerns the family home was unsafe as utilities were turned off, and SS1 was observed with bruising on his arm from being struck with a belt by SF.

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

Basis for Determination:
NCDSS interviewed SM and SF, both of whom denied the allegations surrounding striking SS1. NCDSS followed up with the pediatrician as a collateral contact, and no concerns were noted for either CH. NCDSS interviewed SS1 at school

regarding the initial report and he stated SM hit him in the eye. NCDSS did not find SS1 credible based on his behavioral issues, and that his stories changed during their only 2 verbal contacts with the CH throughout the 7 months the investigation was open. NCDSS unfounded the report and closed.

OCFS Review Results:
NCDSS did not complete an adequate investigation into the concerns received in these reports. A CPS history review was not documented. NCDSS did not appropriately address the allegations received, nor continually or adequately assess the safety of the SS's throughout their involvement with the family. NCDSS did not request police records despite allegations of DV and historical cases noting DV. The RAP was completed inaccurately. Notices of Existence (NOEs) were not sent to BF of SS1 until 3/17. NOEs were not sent to SM or SF for the 2/2/17 report. BF was never interviewed. Appropriate services were not offered to the family.

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

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
NCDSS CW observed marks/swelling around SS1's eye on 12/16/16 and did not complete a home visit until 12/30/16. SM informed NCDSS the family would be staying with a relative until appropriate housing was acquired, but NCDSS did not assess this relative's home for safety. There was no contact with the family for approximately 3 months, despite the alleged concerns.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
NCDSS will conduct complete and adequate investigations that explore and address all allegations fully as they arise.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
NCDSS did not request police records despite allegations of DV and historical cases noting DV. The school noted many concerns regarding SS1s behaviors, but NCDSS did not adequately follow up with SM or the school to see what, if anything, SM had been doing to address the 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:
Failure to Offer Services
Summary:
Appropriate services were not offered to the family. The parents may have benefited from parenting classes and/or services to assist with SS1s ongoing behavioral issues. Despite a history of DV, DV services were not discussed with or referred to SM.
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:
A CPS history check was not completed for the initial report, nor any of the subsequent reports.
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 Risk Assessment Profile (RAP)
Summary:
The question regarding threatening/abusive incidents (#7) was answered "No" when it should have been "Yes", as past cases note SM had a history of DV relationships with SS1's BF and SF.
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:
Adequacy of face-to-face contacts with the child and/or childs parents or guardians
Summary:
There were no documented attempts to interview SS1's BF.
Legal Reference:
432.1 (o)
Action:
NCDSS will make 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:
Failure to provide notice of report
Summary:
Notice of Existence Letters were not mailed/delivered to SS1's BF until 3/17/17.
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.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
NCDSS did not gather any information surrounding SS1's swollen and scratched eye or how SS1 may have sustained the injury. NCDSS did not ask questions regarding how SS1 sustained a bruise on his arm, nor explore allegations of DV occurring in the home via interviews with SS1 or other collateral sources. NCDSS did not appropriately explore the concerns surrounding the home and utilities.
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:

Timely/Adequate Case Recording/Progress Notes

Summary:

Most progress notes were entered one month or later after their event dates.

Legal Reference:

18 NYCRR 428.5(a) and (c)

Action:

NCDSS will enter progress notes contemporaneously as events occur.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/02/2015	Sibling, Male, 4 Years	Mother, Female, 27 Years	Excessive Corporal Punishment	Unfounded	Yes
	Sibling, Male, 4 Years	Mother, Female, 27 Years	Lacerations / Bruises / Welts	Unfounded	
	Sibling, Male, 4 Years	Father, Male, 25 Years	Excessive Corporal Punishment	Unfounded	
	Sibling, Male, 4 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 4 Years	Father, Male, 25 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 4 Years	Father, Male, 25 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:

This report was received by Erie County Department of Social Services (ECDSS) with concerns SM and SF were using excessive force when disciplining SS1 on an ongoing basis. The report alleged SS1 had sustained scratches and lacerations to his face, as well as bruises on his back, legs, and arms from being hit by SM and SF.

Determination: Unfounded | **Date of Determination:** 01/08/2016

Basis for Determination:

ECDSS interviewed all household members, observed home environments, and addressed the allegations in the report. During this investigation, SM gave birth to SS2, and safe sleep was reviewed with the parents. ECDSS assigned NCDSS a secondary role to continue to assess the safety of the SS after moving out of Erie County. ECDSS found no evidence to substantiate the allegations, and closed the case.

OCFS Review Results:

Services were not offered to SF prior to case closure. ECDSS did not follow up with SM or SF regarding concerns found in recent police reports regarding SM using excessive force with SS1 in a bus terminal, or SF being arrested for possession of marijuana, cocaine, and drug paraphernalia. ECDSS did not document any attempts to meet with SS1's BF face to face, or speak with him regarding the concerns.

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

Issue:

Failure to Offer Services

Summary:
Although the assigned secondary county offered SM services, the record did not reflect if ECDSS directed the secondary county to offer appropriate services to SF prior to case closure.
Legal Reference:
SSL 424(10); NYCRR 428.6
Action:
Following the initiation of the investigation, the primary district is responsible for arranging for services for family members within the primary district and requesting the secondary district to provide needed services to family members in their district.
PIP Requirement:
This citation is regarding an investigation that was conducted by Erie County Department of Social Services.

Issue:
Adequacy of face-to-face contacts with the child and/or childs parents or guardians
Summary:
The record did not reflect any attempts to interview the BF of SS1 face to face.
Legal Reference:
432.1 (o)
Action:
ECDSS will make 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.
PIP Requirement:
This citation is regarding an investigation that was conducted by Erie County Department of Social Services. In an effort to address this concern, ECDSS has recently issued additional guidance to staff with respect to interviewing non-custodial parents.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
During the investigation, police reports were received that noted recent concerns regarding SM using excessive force toward SS1 in a bus terminal, and an arrest of SF for possession of drugs and drug paraphernalia. ECDSS did not follow up with SM or SF regarding these concerns.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
ECDSS will conduct complete and adequate investigations that fully address and explore all concerns as they arise.
PIP Requirement:
This citation is regarding an investigation that was conducted by Erie County Department of Social Services.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP question regarding negative affects of drug use pertaining to SF was answered "No" when it should have been "Yes", as ECDSS received a police report showing SF was arrested for drug possession in August 2014.
Legal Reference:
18 NYCRR 432.2(d)
Action:

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

PIP Requirement:

This citation is regarding an investigation that was conducted by Erie County Department of Social Services.

[redacted]

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

4/2011: UNF against SM for IG regarding SS1.
6/2014: UNF against SM for IG regarding SS1.

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

Known CPS History Outside of NYS

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

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? There was no legal activity

Recommended Action(s)

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

Action:	During an investigation conducted by ECDSS in December 2015, the case composition listed SM initially residing in a household with MGM, MGF, MA and 2yo child. Although SM moved to a different county during the investigation, and the other persons in the home were listed as having No Role, they were still involved in an open Child Protective Investigation. Best casework practice would have been to assess any possible needs of the family members, especially regarding the 2yo child, and offer such services if available and necessary.

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