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Local Commissioners Memorandum

Transmittal:	11-OCFS-LCM-01
To:	Local District Commissioners
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Subject:	**Guidance for CPS Investigations Involving Activities Regulated by Other Local or State Agencies**
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Filing References

Previous ADMs/INFs	Releases Canceled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
10-OCFS-LCM-15		18 NYCRR Part 432	§ 20(5) SSL; Article 6 of Title 6 of the SSL		

I. Purpose

The purpose of this Local Commissioners Memorandum (LCM) is to provide guidance to Child Protective Services (CPS) staff regarding the investigation and determination of CPS reports, including fatality reports, which involve activities that are also subject to regulation or oversight by government agencies outside of the child welfare system. This LCM will examine the implications of such regulation or oversight when applying the statutory standards for abuse and maltreatment under the Social Services Law (SSL) and the Family Court Act (FCA). In regard to the investigation and determination of CPS reports involving allegations of maltreatment, the LCM will focus on the issue of whether the subject of the report failed to exercise a minimum degree of care and, in so doing, whether the child was impaired or placed in imminent danger of impairment.

II. Background

For over twenty years, the New York State Office of Children and Family Services (OCFS) and its predecessor, the New York State Department of Social Services, have issued reports on the deaths of children, including those reported to the Statewide Central Register of Child Abuse and Maltreatment (SCR). As required by section 20(5) of the SSL, each of these reports has examined the cause of the death of the child identified in the report.

In the course of preparing and issuing these reviews, OCFS has identified issues and trends concerning child fatalities and, based on that experience, has determined to issue a series of guidance documents for the field. One recent example is the issuance of a release on investigating infant fatalities and injuries involving unsafe sleeping conditions in 10-OCFS-LCM-15.

When preparing fatality reports pursuant to section 20(5) of the SSL, OCFS has observed cases in which the facts involve activities or circumstances that are subject to some form of regulation or oversight by other local or state government agencies. Such activities or circumstances include, but are not limited to, the following:

1. Child Safety Restraints
2. Helmet Use (Bicyclists, In-line Skaters)
3. Home Swimming Pool Safety
4. Operation of All-Terrain Vehicles (ATVs), snowmobiles and other motor vehicles
5. Use of Firearms
6. Operation of Farm and Industrial Equipment

The fact patterns observed by OCFS are statewide and occur in urban, suburban and rural settings throughout the State of New York.

It is important to note that the issues discussed in this release apply equally to reports made to the SCR that do not involve the death of a child. While reports of child fatalities attract the most attention, the discussion in this LCM is equally relevant to CPS reports that involve non-fatal injuries or those in which a child has been placed in imminent danger of injury.

This LCM is intended to address how CPS should apply the standards established by other local or state government agencies when making a determination of abuse or maltreatment in regard to a pending CPS report.

III. Program Implications

When a social services district receives a report of suspected child abuse or maltreatment, it must conduct an investigation in accordance with the statutory standards set forth in sections 411-428 of the SSL and OCFS regulations at 18 NYCRR Part 432. In determining whether to substantiate or unsubstantiate an allegation or whether to either indicate or unfound a report, the social services district must apply the statutory standards for an abused or maltreated child as set forth in sections 412 of the SSL and 1012 of the FCA.

In the course of investigating a report, CPS may encounter circumstances in which the activities involved are also subject to an assessment of compliance with standards established by other local or state government agencies. Many such scenarios are very familiar to CPS, such as cases involving a child who is involved in a motor vehicle accident and who was not wearing a seat belt. Others are less commonly encountered, such as children operating motor vehicles or machinery.

When investigating a report made to the SCR, CPS should ascertain if there is such a local or state standard otherwise applicable to the circumstances of the case, whether there was compliance or non-compliance with the standard, and how compliance or non-compliance relates to the determination of the CPS report. The conclusion that there was compliance or non-compliance with the local or state non-child-welfare standard is not, in and of itself, decisive or controlling in determining whether the child was abused or maltreated in accordance with the definitions in the SSL and the FCA. CPS must apply

all of the facts identified during the CPS investigation against the elements of the statutory definitions of abuse or maltreatment in the SSL and the FCA.

Most of the cases that fall within the scope of this LCM contain allegations that relate to maltreatment, and not to abuse. That is, most commonly, the allegation is not that the subject of the report inflicted or allowed the infliction of serious harm to the child. Rather, in most of these cases, the issue is whether the subject of the report failed to exercise a minimum degree of care and, in so doing, whether the child was impaired or placed in imminent danger of impairment. This is in contrast with the standard used by medical examiners and coroners in fatality cases, where the common pre-eminent cause of death finding by the medical examiner or coroner is accidental death (as contrasted to homicide, which connotes the intentional act of someone to harm the child). **The fact that a medical examiner or coroner report rules a death as "accidental" does not mean that there was not child abuse or maltreatment under the definitions in the SSL and FCA. An "accidental death" ruling by a medical examiner or coroner is relevant to the CPS investigation but must not control the outcome of the CPS investigation.** Similarly, the determination of other local and state government agencies as to compliance or non-compliance with a non-child-welfare standard may be relevant to the determination in a CPS case, but it is not controlling. The CPS investigation must arrive at a determination using the child abuse and maltreatment definitions, as set forth in the SSL and FCA.

To demonstrate this point, the following are examples of sets of facts that CPS may encounter in which there is an issue of compliance with a non-child-welfare standard:

Example A
A parent operates a motor vehicle and fails to place his or her child in an age-appropriate child safety restraint. The parent operates the motor vehicle in excess of the speed limit and is intoxicated. The parent drives into another car; the child is ejected and dies. The opinion of law enforcement and a medical professional is that the child would have not died had the child been properly restrained.

Example B
A parent places his/her two children into age-appropriate child restraints. While the parent is driving, one child removes the child restraint without the parent's knowledge and just before the accident, so the parent has no opportunity to notice that the child is out of the restraint. The parent otherwise drives the car obeying applicable motor vehicle standards. The parent's car is struck by a truck, the parent is ejected from the car, the parent's car bursts into flames, and the two children (both the child who is restrained and the child who removed the restraint) are trapped in the car and die in the fire.

Example C
A parent allows a 10 year-old-child to ride the child's bicycle at night wearing dark clothing and no helmet. The child is struck by a car, suffers a head injury and dies from the head injury that medical professionals conclude would not have occurred if the child was wearing a helmet.

Example D
A parent allows a 10 year-old-child to ride the child's bicycle without a helmet during the day to a friend's house across the street. While riding the bicycle across the street, the child is struck in the chest by a stray bullet fired during the commission of a crime not involving the child's family, and the child dies from the gunshot wound.

In all four examples there was a violation of either the child safety restraint or bicycle helmet standards. However, non-compliance with such rules in Examples B and D is not relevant or controlling to the issue of whether a child was abused or maltreated, while the facts surrounding the failure to comply with such standards are relevant in Examples A and C. In examples A and C, the violation of the non-child-welfare law (the child safety restraint law in A and the bicycle helmet law in C) constituted a failure by the parent to exercise a minimum degree of care, and that failure contributed to the death of the child in each example. In example B, there was a violation of the non-child-welfare law (the child safety restraint law), but that violation did not constitute a failure to exercise a minimum degree of care by the parent. Further, the violation of the child safety restraint law did not contribute to the death of either child. In example D, the parent failed to exercise a minimum degree of care by permitting the violation of the non-child-welfare law (the bicycle helmet law), but that failure to exercise a minimum degree of care did not contribute to the death of the child.

The same analyses would apply in a CPS report that contained a non-fatality situation in which non-child-welfare local or state requirements apply.

Another example of an area in which non-child welfare standards are likely to be encountered by CPS is in regard to reports involving swimming pools. Swimming pool safety is regulated at the state level by the State Fire Prevention and Building Code and is often also regulated at the local level by more restrictive requirements.

Again, some examples for illustration:

Example E
A two-year-old child resides in a home that has a backyard in-ground swimming pool that lacks any barrier preventing or impeding access to the swimming pool. The applicable local building code requires that in-ground swimming pools be surrounded by a fence. The two-year-old child exits the home through an unlocked back door and falls into the pool. Fortunately, the parent observes the child falling in and is able to rescue the child from the pool. The child is not seriously injured.

Example F
A seventeen-year-old hosts a pool party for the youth's high school swim team at the youth's home that has an in-ground pool. The party is sanctioned by the parents and the parents arrange for an otherwise responsible adult sibling to supervise the party. The parents provide clear directions to both the older sibling and the youth regarding the rules of conduct during the party. There is no history of the failure by either the adult sibling

or the youth to follow parental directions. The parents advise the adult sibling and the youth to call them if either experiences any problems.

There is a defect in the latch to the gate to the swimming pool, which is in violation of the local building code.

During the party, the youth breaks his leg. An SCR report is accepted on the basis that there is suspicion that alcohol may have been involved and there is a question as to whether the adult sibling was present at the time of the injury.

Example E reflects a situation in which there was a violation of a non-child-welfare safety requirement that was directly relevant to the underlying issues in the CPS report. The absence of compliance with such requirement goes to the issue of the failure of the subject(s) of the report to exercise a minimum degree of care, and would thus be relevant as part of the CPS investigation and determination.

In Example F, there was a violation of a local code, but the fact that the latch was broken was not relevant to the allegations of the CPS report that the subject(s) of the report allegedly failed to adequately supervise the youth and failed to provide adequate guardianship. Therefore, regardless of whether the broken latch represented a failure to exercise a minimum degree of care by the subject(s) of the report, it is irrelevant to the CPS determination. Of course, findings will vary based on the facts of the case. In regard to the facts of Example F, following a complete investigation, it would be reasonable to conclude that the parents exercised a minimum degree of care in the situation at issue in this CPS report.

Similarly, the fact that there was compliance with local or state non-child-welfare standards is not controlling in regard to the determination of whether a child was abused or maltreated under the SSL or the FCA when the facts of the case otherwise satisfy the definition of abuse or maltreatment.

An example of this point may be seen in regard to the operation of ATVs by children. When, where, and who may operate an ATV is regulated by the New York State Vehicle & Traffic Law. Guidance on the applicable standards may be found on the New York State Department of Motor Vehicles website http://www.nydmv.state.ny.us.

The standards regarding who may drive an ATV and where include:

1. Children 10 to 15 years of age can drive an ATV only:

    a) With adult supervision, or
    b) Without adult supervision on property where their parent or guardian is the owner or tenant, or
    c) Without adult supervision on property where ATV use is permitted and the child has completed an ATV safety-training course approved by DMV.

2. Children under 10 years of age may drive an ATV only:

   a) With adult supervision, or
   b) Without adult supervision on property where their parent or guardian is the owner or tenant.

NOTE: Such standards may change, so please determine what the current standard is for any future cases.

OCFS is not saying that the use of an ATV by a child in and of itself constitutes abuse or maltreatment. However, while it may not be a violation of the Vehicle & Traffic Law, for example, for a child under the age of 10 to operate an ATV on the child's parent's property, where a report is made to the SCR that involves a child under the age of 10 using an ATV, CPS is authorized and is required to examine other facts of the case in determining whether the child has been abused or maltreated. Factors not taken into consideration by the Vehicle & Traffic Law, for example, include: the physical capacity and maturity of the child, the child's familiarity with the machine, the terrain in which the child traveled, the child's driving experience and history, and even the weather conditions and time of day. None of these additional factors is relevant to determining whether there was a violation of the Vehicle & Traffic Law, but all would be relevant to determining whether there was child abuse or maltreatment.

Again, as with any CPS report, the social services district must apply the facts developed during the investigation against the statutory standards set forth in the SSL and the FCA. If, for example, a child under age 10 who had never before operated an ATV was permitted by the parent to drive an ATV on the parent's property without adult supervision in icy conditions near a large open pit, and the ATV skidded on the ice and went into the pit resulting in an injury to the child, there would be no violation of the Vehicle & Traffic Law, but there would be a basis to indicate a CPS report.

A final point relating to those CPS reports involving a fatality is the criteria used in determining whether to substantiate the DOA/Fatality allegation, especially when there is an underlying allegation such as inadequate guardianship, medical neglect, etc. OCFS policy on this issue is reflected in 10-OCFS-LCM-15, which states on page 9:

"If there is no credible evidence to support the underlying allegation(s), it is reasonable to conclude that the DOA/Fatality allegation should not be substantiated."

"If the underlying allegation(s) is substantiated, then CPS should assess whether there is a nexus (causal connection) between the injury, harm, risk of injury, or risk of harm that was substantiated in the underlying allegation with the death of the child. (For example, did the underlying failure to exercise a minimum degree of care cause the death of the child?) If there is, then the DOA/Fatality allegation should be substantiated."

It is not possible to predict all of the fact patterns that CPS will face. However, the standard practice of uniformly conducting a complete and thorough investigation and

then applying the facts developed in the investigation against the legal definitions of child abuse and maltreatment set forth in the SSL and the FCA will go a long way to reaching consistent and accurate determinations.

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