



Report Identification Number: BU-21-037

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

Issue Date: Jun 15, 2022

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	ASTO-Allowing Sex Abuse to Occur	



Case Information

Report Type: Child Deceased
Age: 6 month(s)

Jurisdiction: Chautauqua
Gender: Female

Date of Death: 12/23/2021
Initial Date OCFS Notified: 12/23/2021

Presenting Information

Two SCR reports received on 12/23/21, alleged the 6-month-old subject child (SC) was in the care of the maternal grandparents (MGP). The grandfather (MGF) placed the SC in the portable crib for the night. The MGF checked on the SC at 3:18 a.m., and the SC was found unresponsive and not breathing. The MGM called 911 and the MGF started CPR. The SC had multiple bruises in different stages of healing about the body. The injuries and bruises appeared to be inflicted and there was no explanation provided. The SC died as a result of cardiac arrest, while in the MGP care. It was unknown if the injuries contributed to the SC's death and the cause of death was unknown. The home was cluttered with narrow walkways and had unsanitary living conditions. Cockroaches were observed crawling on the surviving sibling (SS) in the portable crib. An additional SCR report received on 3/16/22, alleged that the MGP failed to adequately supervise the SC and the SC ingested methamphetamine.

Executive Summary

This fatality report concerns the death of the 6-month-old female subject child, that occurred on 12/23/21. The report alleged the child was found unresponsive while in the care of the maternal grandparents. At the time of the child's death, she and the 2-year-old surviving sibling were in the custody of the mother but were staying with the maternal grandparents. The father had minimal contact with the children due to his history of drug use and homelessness. Chautauqua County Department of Social Services (CCDSS) had an open CPS investigation at the time of the death. The report open at the time of death was received 12/16/21 and alleged concerns of drug use by the mother and the parent substitute in addition to concerns the home was a safety hazard to the children. A subsequent SCR report received on 3/16/22, alleged that the maternal grandparents failed to adequately supervise the child and she ingested methamphetamine.

The grandparents reported caring for the child and her sibling at the time of the fatal incident. The grandparents reported the child was placed in the portable crib around 9:30pm. The grandfather reported he woke in the middle of the night and checked on the children and the child did not move when he touched her. The grandmother called 911, and the grandfather started CPR. The child was brought to the hospital, where life saving measures continued but were unsuccessful. Medical staff had expressed concerns for bruising on the child's body in multiple stages of healing. CCDSS gathered information from collateral contacts, including hospital staff, the pediatrician, coroner, medical examiner, first responders and family members.

Following the child's death, CCDSS assessed the safety of the surviving sibling. CCDSS determined the subject mother, and the father were unable to meet the needs of the surviving sibling and she was removed from the parents' care and placed in foster care. A Neglect Petition was filed against the mother, father and maternal grandparents. The matter was pending in Family Court at case closure.

CCDSS coordinated investigative efforts with law enforcement upon receipt of the SCR report. The criminal investigation was still pending, and no criminal charges had been filed at the time this report was written. According to the Medical Examiner, the child had methamphetamine in her system at the time of death and was also positive for a virus. An autopsy was performed; however, the results were pending at the time this report was written.

CCDSS referred the mother for mental health and grief counseling, and a substance abuse evaluation. At the close of the investigation the mother had not enrolled in any of the services offered. CCDSS set up and provided visitation with the



parents for the surviving sibling in foster care.

The allegations of Malnutrition/Failure-to-Thrive, Inadequate Guardianship, and Inadequate Food/Clothing/ Shelter were substantiated against the mother and maternal grandparents regarding the child and surviving sibling. The allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter were substantiated against the father regarding the surviving sibling. Lacerations/Bruises/Welts was substantiated against the mother and maternal grandparents regarding the child. The allegations of DOA/Fatality were unsubstantiated against the grandparents, as the ME was awaiting toxicology reports to determine the cause of death. The parent substitute that resided in the home was not interviewed. Allegations were not added against him even though he resided in the home and was a person legally responsible for the child and the surviving sibling. CCDSS determined the conditions of the home were unsafe for the subject child and the surviving sibling. The mother and the parent substitute acknowledged exposing the children to the unsafe living condition thereby failing to provide a minimum degree of care.

PIP Requirement

CCDSS will submit a PIP to the Buffalo Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the CCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDSS 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:

Casework activity was not commensurate with case circumstances. The parent substitute was not interviewed and indication letters were not provided to the required adults.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No



Was there sufficient documentation of supervisory consultation?

Yes, the case record has detail of the consultation.

Explain:

The SS remained in foster care at the writing of this report and the family court action continued regarding the SM, BF, MGM and MGF regarding the SS.

Required Actions Related to the Fatality

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

Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	CCDSS did not interview the parent substitute during the fatality investigation. The parent substitute was an established PLR for the children and lived in the mother's home at the time of the fatal incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.
Issue:	Failure to Provide Notice of Indication
Summary:	The record did not reflect that CCDSS provided indication letters to the subject(s) and other persons named in the report.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	CCDSS shall deliver or mail to the subject(s) and other persons named in the indicated report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/23/2021

Time of Death: 05:00 AM (Approximate)

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

Unknown

County where fatality incident occurred:

Chautauqua

Was 911 or local emergency number called?

Yes

Time of Call:

Unknown

Did EMS respond to the scene?

Yes

At time of incident leading to death, had child used alcohol or drugs?

Yes

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? 6 Hours

At time of incident was supervisor impaired? Unknown if they were impaired.

At time of incident supervisor was:

Distracted

Absent

Asleep

Other:

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	Female	6 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	29 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	47 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Male	47 Year(s)
Other Household 2	Father	Alleged Perpetrator	Male	23 Year(s)

LDSS Response

After receiving SCR notification of the death on 12/23/21, CCDSS contacted the sources of the reports and notified the DA of the death. They spoke with collaterals including law enforcement, hospital staff, the medical examiner, the pediatrician, and family members.

Hospital staff reported that the SC was brought into the hospital in cardiac arrest and was unable to be revived and bruises were noted in different areas of the SC's body in different stages of healing.

The ME reported the preliminary findings of the autopsy showed no obvious signs of physical trauma to the SC. The ME reported the SC did have a virus at the time of her death and that methamphetamine was found in her system. The autopsy report had not been completed or received at the time this report was written.

CCDSS met with the MGM and MGF at their residence. The MGM and MGF stated the SC, and the SS were with SM from 12/19/21 until about 7pm on 12/20/21 when they returned to the MGP's home. The MGP denied that anything out of the ordinary happened on 12/22/21. The MGM reported that the SC was unable to sit up on her own and was not yet crawling. The MGM reported that the SC had no issues with eating or taking bottles on 12/22/21. The MGP reported that the SC was laid on her back, in the portable crib around 9:30 pm, with a small baby blanket up to her stomach area. The MGF stated that he woke up in the middle of the night and checked on both children and when he touched the SC she did not move. The MGF told the MGM to call 911 and he began CPR on the SC. The SC's portable crib was observed to be empty by CCDSS during the home visit. The MGP's both denied the SC had any bruising, except for a small bruise on her cheek that she received as a result of the SS hugging her. The MGF reported he thought there was a was diaper rash on SC's buttocks. The MGP's were made aware of the drug found in the SC's system at the time of her passing. The MGM denied using the drug and the MGF reported only using marijuana, but both stated concerns for the SM using the drug.



On 12/23/21, the SS had a medical exam performed by her pediatrician. The pediatrician said that the SM was inconsistent with getting the SC and SS to well care visits. The pediatrician was historically concerned about the the weight gain for both children. The SS also had a significant diaper rash that needed to be prescribed medication. The SS had a full skeletal survey completed on 12/23/21, that was found to be unremarkable.

CCDSS met with the SM at her residence. The SM was inconsistent regarding how often the SC and SS had been staying with the MGP. The SM denied seeing the SC with any bruises. The SM was made aware of the SC’s positive toxicology for methamphetamine at the time of her passing. The SM denied having the SC at the time of death and responsibility for the drug in the SC’s system. The SM reported that the MGF used drugs and she had bought drugs from him in the past. The report reflected there were significant concerns for the SM’s stability with regards to her mental health, substance use and the ongoing concerns of the home not meeting safety standards for the SS. The SM was unable to identify any appropriate resources for the SS. Due to the ongoing safety concerns the SS was placed into foster care on 12/23/21, and she remained in placement at the time this report was written. CCDSS saw the parent substitute at the SM’s home, but he was never interviewed regarding the fatality report.

CCDSS interviewed the BF on 12/23/21. The BF reported he had not seen the children on a regular basis and said the children were with the MGP's often. The BF reported concerns for the PS and thought the SM was doing better. The BF reported not being able to care for the children due to his unstable housing and substance use. The BF admitted to a history of drug misuse, and he had a recent arrest for drugs. CCDSS did not offer services or refer the BF for a substance abuse evaluation.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Pending

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?No

Comments: CCDSS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059869 - Deceased Child, Female, 6 Mons	059927 - Grandparent, Female, 47 Year(s)	DOA / Fatality	Unsubstantiated
059869 - Deceased Child, Female, 6 Mons	059927 - Grandparent, Female, 47 Year(s)	Lacerations / Bruises / Welts	Substantiated
059869 - Deceased Child, Female, 6 Mons	059927 - Grandparent, Female, 47 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
059869 - Deceased Child, Female, 6 Mons	059928 - Grandparent, Male, 47 Year(s)	DOA / Fatality	Unsubstantiated
059869 - Deceased Child, Female, 6 Mons	059928 - Grandparent, Male, 47 Year(s)	Inadequate Guardianship	Substantiated



Child Fatality Report

059869 - Deceased Child, Female, 6 Mons	059925 - Mother, Female, 27 Year(s)	Malnutrition / Failure to Thrive	Substantiated
059869 - Deceased Child, Female, 6 Mons	059925 - Mother, Female, 27 Year(s)	Lacerations / Bruises / Welts	Substantiated
059869 - Deceased Child, Female, 6 Mons	059928 - Grandparent, Male, 47 Year(s)	Malnutrition / Failure to Thrive	Substantiated
059869 - Deceased Child, Female, 6 Mons	059925 - Mother, Female, 27 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
059869 - Deceased Child, Female, 6 Mons	059927 - Grandparent, Female, 47 Year(s)	Inadequate Guardianship	Substantiated
059869 - Deceased Child, Female, 6 Mons	059927 - Grandparent, Female, 47 Year(s)	Malnutrition / Failure to Thrive	Substantiated
059869 - Deceased Child, Female, 6 Mons	059928 - Grandparent, Male, 47 Year(s)	Lacerations / Bruises / Welts	Substantiated
059869 - Deceased Child, Female, 6 Mons	059928 - Grandparent, Male, 47 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
059869 - Deceased Child, Female, 6 Mons	059925 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
059926 - Sibling, Female, 2 Year(s)	059929 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated
059926 - Sibling, Female, 2 Year(s)	059929 - Father, Male, 23 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
059926 - Sibling, Female, 2 Year(s)	059928 - Grandparent, Male, 47 Year(s)	Malnutrition / Failure to Thrive	Substantiated
059926 - Sibling, Female, 2 Year(s)	059928 - Grandparent, Male, 47 Year(s)	Inadequate Guardianship	Substantiated
059926 - Sibling, Female, 2 Year(s)	059927 - Grandparent, Female, 47 Year(s)	Malnutrition / Failure to Thrive	Substantiated
059926 - Sibling, Female, 2 Year(s)	059927 - Grandparent, Female, 47 Year(s)	Inadequate Guardianship	Substantiated
059926 - Sibling, Female, 2 Year(s)	059925 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
059926 - Sibling, Female, 2 Year(s)	059925 - Mother, Female, 27 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
059926 - Sibling, Female, 2 Year(s)	059927 - Grandparent, Female, 47 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
059926 - Sibling, Female, 2 Year(s)	059928 - Grandparent, Male, 47 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
059926 - Sibling, Female, 2 Year(s)	059925 - Mother, Female, 27 Year(s)	Malnutrition / Failure to Thrive	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Child Fatality Report

When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

Although the SS was observed, the record did not reflect there were attempts made to interview the SS.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, court ordered?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explain as necessary: The SM and BF could not provide any appropriate resources for the SS. The SS was placed into foster care under section 1024 of the Family Court Act.				

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:
12/28/2021	There was not a fact finding	There was not a disposition
Respondent:	059925 Mother Female 27 Year(s)	
Comments:	The SS was removed under section 1024 of the Family Court Act and an Article 10 Neglect Petition was filed. The BF later signed a 1021 consent for removal. The Neglect Petition was still pending in Family Court at the writing of this report and the SS remained in foster care.	

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
12/28/2021	There was not a fact finding	There was not a disposition
Respondent:	059929 Father Male 23 Year(s)	



Comments: The SS was removed under section 1024 of the Family Court Act and an Article 10 Neglect Petition was filed. The BF later signed a 1021 consent for removal. The Neglect Petition was still pending in Family Court at the writing of this report and the SS remained in foster care.

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
12/28/2021	There was not a fact finding	There was not a disposition

Respondent: 059928 Grandparent Male 47 Year(s)

Comments: The SS was removed under section 1024 of the Family Court Act and an Article 10 Neglect Petition was filed. The BF later signed a 1021 consent for removal. The Neglect Petition was still pending in Family Court at the writing of this report and the SS remained in foster care.

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
12/28/2021	There was not a fact finding	There was not a disposition

Respondent: 059927 Grandparent Female 47 Year(s)

Comments: The SS was removed under section 1024 of the Family Court Act and an Article 10 Neglect Petition was filed. The BF later signed a 1021 consent for removal. The Neglect Petition was still pending in Family Court at the writing of this report and the SS remained in foster care.

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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Child Fatality Report

Alcohol/Substance abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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:

The SS received a full medical examination and x-rays following the SC's death. The SS also received Foster Care services.

History Prior to the Fatality

Child Information

- Did the child have a history of alleged child abuse/maltreatment? 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 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)	Allegation Outcome	Compliance Issue(s)
12/16/2021	Deceased Child, Female, 6 Months	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Deceased Child, Female, 6 Months	Mother, Female, 27 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 6 Months	Mother, Female, 27 Years	Lack of Supervision	Unsubstantiated	



Deceased Child, Female, 6 Months	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 1 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 1 Years	Other Adult - Parent Substitute, Male, 29 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 1 Years	Other Adult - Parent Substitute, Male, 29 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 6 Months	Other Adult - Parent Substitute, Male, 29 Years	Inadequate Food / Clothing / Shelter	Substantiated
Deceased Child, Female, 6 Months	Other Adult - Parent Substitute, Male, 29 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 6 Months	Other Adult - Parent Substitute, Male, 29 Years	Lack of Supervision	Unsubstantiated
Deceased Child, Female, 6 Months	Other Adult - Parent Substitute, Male, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:

An SCR report alleged, the SM and PS of a young child were using and selling drugs in the home. They left the young child locked in a room all day long and the child screamed. The SM and PS blasted music and did not check on the child, so the child was without supervision. The home had garbage piled up to the ceiling.

Report Determination: Indicated

Date of Determination: 02/14/2022

Basis for Determination:

Throughout the investigation the conditions of the home were unsafe for the SC and SS. Throughout the SM's home, there was an excessive amount of clutter, dirty dishes, bikes, garbage overflowing, tripping hazards, and the CW was not able to enter the bedroom where the children had reportedly slept due to a lack of a clear pathway. The SM and PS acknowledged exposing the children to these unsafe living conditions. The SM and PS failed to provide a minimum degree of care to the children by exposing them to these unsafe living conditions. There were concerns for SM's substance misuse and untreated mental health having a negative impact on her ability to care for the children.

OCFS Review Results:

The record did not reflect that CCDSS entered progress notes in a timely manner or that they provided indication letters to the required adults. CCDSS allowed the SM to continue to utilize the MGM as a safety plan despite the MGM's extensive CPS history. CCDSS did see all family members and offered the family services, which the family declined. There was no evidence of the SM or PS using or selling drugs in the home and were observed to be sober during all visits made by CCDSS. Due to a previous safety plan the SC and SS were primarily residing with the MGP's.

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

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

The record reflected that 35 out of 59 progress notes were not entered contemporaneously during the investigation.

Legal Reference:

18 NYCRR 428.5

Action:

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.



Issue:

Failure to Provide Notice of Indication

Summary:

The record did not reflect that CCDSS provided indication letters to the required adults in the home.

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

Action:

CCDSS shall deliver or mail to the subject(s) and other persons named in the indicated report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/05/2021	Sibling, Female, 1 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Female, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 2 Months	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 2 Months	Mother, Female, 27 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 2 Months	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 2 Months	Father, Male, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 2 Months	Father, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 2 Months	Father, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

An SCR report alleged the SM and BF had a long history of drug use. The parents were using methamphetamine and heroin in the home, in the presence of their children, SS (then 1) and SC (then 2-months-old). While the parents were under the influence of these drugs, they were incapable of providing adequate care to the young children. There were concerns for the ongoing unsanitary living conditions of the home. The parents had failed to address the concerns. A subsequent report, dated 9/20/21, alleged there was a physical altercation that took place between the BF and another male, near the SC. The SC was placed at risk but not injured.

Report Determination: Indicated

Date of Determination: 11/10/2021

**Basis for Determination:**

The parents took the SC and SS to a drug house at least twice, during the investigation, despite CCDSS warnings. During one of these visits to the drug house, the CHN were discovered to be in very close proximity to an individual smoking marijuana. It was difficult to confirm that the SM and BF were under the influence while directly responsible for the care of the CHN. The MGM was the CHN's primary caretaker, but had no custodial rights, and could not take the CHN to the doctor. As a result, the SC had not been seen by the doctor since July. Neither the SM nor BF acted in a reasonable or prudent manner and the case was indicated and closed. The condition of the home met minimal standards.

OCFS Review Results:

SCR history was not reviewed within 1 business day and was not documented within 5 business days after the report was received. Notification letters and indication letters were not provided to the required adults. The record did not reflect the source of the SUB report was contacted. CCDSS did not follow up with law enforcement regarding the BF's altercation and arrest on the SUB report. Multiple progress notes were entered untimely. CCDSS missed the opportunity to offer the BF services for substance misuse. CCDSS did not consult with the legal department to assess the need for Family Court action. CCDSS did not make an appropriate safety plan or determine the allegations appropriately.

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

Issue:

Review of CPS History

Summary:

The record reflected that the CPS history check was completed untimely. The SCR report was received on 8/5/21; however, the history check was completed on 8/11/21.

Legal Reference:

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

Action:

Within 1 business day of a report, CCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, LDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:

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

Summary:

CCDSS did not attempt to contact or interview the BF regarding the initial report and he was listed as an alleged subject. The BF was contacted and briefly interviewed regarding the subsequent report on 10/7/2021, but he was never fully interviewed.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

CCDSS missed opportunities to gather collateral information from the SM's and BF's previous substance use providers and law enforcement regarding the BF's recent arrest/charges regarding the subsequent report. The record also did not reflect that CCDSS contacted the source of the subsequent report dated 9/20/2021.

Legal Reference:

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

Action:

CCDSS 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 record did not reflect that CCDSS provided notification letters to the SM and BF regarding the subsequent report.

Legal Reference:

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

Action:

CCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:

Assessment as to need for Family Court Action

Summary:

CCDSS did not document consulting their legal department regarding ongoing concerns for the SC and SS's lack of medical care, health and safety hazards in the home, the parents' drug use and the SM's utilization of the MGM as a caretaker for the CHN despite the MGM's extensive CPS history.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:

CCDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:

Failure to Offer Appropriate Services

Summary:

CCDSS did not adequately assess or offer the family services to address the concerns identified during the investigation. The BF admitted to actively using methamphetamines and CCDSS missed the opportunity to offer the BF services for his substance misuse.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation conducted, CCDSS shall offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Issue:

Failure to Provide Notice of Indication

Summary:

The record did not reflect that CCDSS provided indication letters to the required adults.

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

Action:

CCDSS shall deliver or mail to the subject(s) and other persons named in the indicated report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

Issue:

Appropriateness of allegation determination

Summary:



The allegation of IG was substantiated against the parents regarding the SC and unsubstantiated regarding the SS. Both CHN were observed in a drug house and in close proximity to an individual using marijuana. The CHN had not been seen at the doctor since July 2021. The SM did not take the CHN to the doctor or provide the MGM with the legal authority to take the CHN to the doctor.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

CCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Regional Office if further guidance is needed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/09/2021	Sibling, Female, 1 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Female, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

An SCR report alleged the SM and BF abused methamphetamine and other substances daily, to the point of impairment, while caring for the SS. While impaired, the parents acted irrationally, engaged in verbal arguments, and broke things. The family's residence was a health and safety hazard for the SS. There was old food, garbage, and debris all over the home, a bug infestation, and a strong odor of cat urine and feces. Due to all the clutter, it would have been difficult to leave quickly in case of an emergency. It was unknown if the SS had ever been physically harmed because of the ongoing issues.

Report Determination: Unfounded

Date of Determination: 05/13/2021

Basis for Determination:

The SM and BF stated that they had been having issues with the landlord and were looking to move to another residence. The home met minimal health and safety standards during home visits. The SM and BF denied any drug use and were observed to be sober and coherent when talking with CWs. No drugs or paraphernalia were observed in the home. There was no credible evidence to support the allegations, therefore the report was unfounded and closed.

OCFS Review Results:

CCDSS missed opportunities to gather collateral information, such as medical information from the pediatrician regarding the SS. CCDSS did not provide notification letters to the required adults in a timely manner.

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

Issue:

Failure to provide notice of report

Summary:

CCDSS did not provide notification letters to the adults on the report in a timely manner.



Legal Reference:

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

Action:

CCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

CCDSS missed opportunities to gather collateral information, such as medical information from the pediatrician regarding the SS.

Legal Reference:

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

Action:

CCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the child(ren).

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/18/2021	Sibling, Female, 1 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Female, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

An SCR report alleged the SM's home was deplorable. There was garbage, dirty dishes, old food, dirty clothes, and 3 feet of debris strewn throughout the residence. The heater was sparking, the SM and BF refused to allow others in to fix the issues; this posed as a fire hazard. There were needles strewn throughout the yard. The residence was a health and safety hazard for the children. The parents were abusing substances to the point of impairment and they slept all day.

Report Determination: Unfounded

Date of Determination: 03/23/2021

Basis for Determination:

CCDSS assessed the home on multiple occasions and the home met minimal health and safety standards. The home was messy, but no safety hazards were observed. The SM and BF denied drug use and appeared sober and coherent during casework contacts. No drugs and/or paraphernalia were observed in the home. There was no credible evidence to support the allegations therefore this report was unfounded, and the case was closed.

OCFS Review Results:

CCDSS did not provide Notice of Existence letters to the required adults in a timely manner. CCDSS did make home visits, completed the Safety Assessment on time and accurately, and a safe sleep environment was seen and assessed.



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

Issue:

Failure to provide notice of report

Summary:

CCDSS did not provide notification letters to required adults in a timely manner.

Legal Reference:

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

Action:

CCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/01/2020	Sibling, Female, 8 Months	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Sibling, Female, 8 Months	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Months	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 8 Months	Father, Male, 22 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 8 Months	Father, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Months	Father, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

An SCR report alleged the parents' smoked marijuana while being the sole caregivers to the SS, and while under the influence they were unable to care for the SS. The home was a health and safety hazard. There was garbage, cat urine and feces all over the floors and an infestation of fruit flies and bed bugs in the home. Dirty dishes and baby bottles were left in stagnant water for weeks and the dirty bottles were used for the SS to drink from. There was old food, and sharp objects laying around accessible to the SS. The SS did not have her diaper changed often and was not bathed regularly so the SS constantly appeared dirty. The SM and BF were aware, but they failed to rectify the problems.

Report Determination: Indicated

Date of Determination: 09/30/2020

Basis for Determination:

On 9/2/20, CWs went to home of the SM and BF and found it to not meet minimal health and safety standards. CW's observed overflowing cat boxes, garbage, clutter, popcorn kernels, cigarette butts, animal feces and choking items all over the floors. The SM confirmed the SS had a fungal infection in her mouth. The SM had the MA care for the SS for several hours at her house while the parents cleaned the home. The home was observed later that evening to meet standards. The home continued to meet minimal health and safety standards on two subsequent home visits. Due to some credible evidence this report was indicated. The parents agreed to work with preventive services.

OCFS Review Results:

CCDSS did not interview the PGGM who resided in the home. Notification letters were not provided to the required adults. CCDSS did not accurately reflect the current or recent history of housing with safety hazards in the RAP. There were ongoing concerns for the mothers' untreated mental health issues and cleanliness of the home. CCDSS failed to document communication with the preventive services CW. The family was not progressing with service plan goals and the case was in the process of closing, therefore it may have been appropriate to consult with their legal department.



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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
The PGM resided at the case address and was listed on the report but was not interviewed by CCDSS.

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

Action:
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
CCDSS did not accurately reflect the the risk element of the family having a history of unsafe or unstable housing.

Legal Reference:
18 NYCRR 432.2(d)

Action:
CCDSS 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:
CCDSS failed to document communication with the prevention services CW regarding the family’s progress with their service plan goals and their lack of cooperation with services.

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

Action:
CCDSS 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:
Assessment as to need for Family Court Action

Summary:
There were ongoing concerns for the SM's untreated mental health issues and cleanliness of the home. The preventive services case was in the process of closing due to the SM's lack of cooperation with services. It would have been appropriate for CCDSS to have consulted with their legal department to assess whether Family Court action was necessary.

Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:
CCDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:
Failure to provide notice of report

Summary:
CCDSS did not provide notification letters to the required adults.

**Legal Reference:**

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

Action:

CCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:

Failure to Provide Notice of Indication

Summary:

CCDSS did not mail indication letters to the required adults.

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

Action:

CCDSS shall deliver or mail to the subject(s) and other persons named in the indicated report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/01/2020	Sibling, Female, 8 Months	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Female, 8 Months	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Months	Mother, Female, 26 Years	Lack of Supervision	Unsubstantiated	

Report Summary:

An SCR report alleged the SM was a daycare provider for six children, ages 2 to 6, at least 3 times a week in her home. The condition of the SM's home was a health and safety hazard, and the children were often left outside on the porch or in the yard unsupervised near a busy road. The SM was aware that there were often drug users on the front porch, yet she allowed the children to spend time there. The 4-year-old, the SM was caring for was not being adequately supervised; the child left the property and ended up wandering the neighborhood for approximately two hours before the child was located. The SM had failed to rectify the problems and failed to protect the children.

Report Determination: Unfounded

Date of Determination: 09/16/2020

Basis for Determination:

The mother was not running a daycare of any sort; there was no exchange of benefits, items, cash etc. for any childcare activity. The parents reported the SM had watched up to three CHN including the SS. A local representative from the childcare council was present and deemed no daycare operations were taking place. On 9/2/20, the home was found to fail minimal standards and the familial CPS worker took corrective action to address the situation. Follow up home visits on 9/2/20 and on 9/9/20 showed the home met minimal standards. The familial CPS investigation and the preventive services case remained open.

OCFS Review Results:

CCDSS did not interview the PGGM who resided in the home during the daycare investigation. There were missed opportunities to contact the SS's pediatrician to verify the SS's health due to the safety concerns in the home. Notification letters were not provided to all required adults. Safe sleep for the SS was not observed and the parents were not provided with safe sleep information.

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

Issue:

Failure to Conduct a Face-to-Face Interview (Subject/Family)

**Summary:**

The PGM resided at the case address and was listed on the report but was not interviewed by CCDSS.

Legal Reference:

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

Action:

A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

There were missed opportunities to gather collateral information, such as medical information from the pediatrician regarding the SS.

Legal Reference:

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

Action:

CCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Issue:

Failure to provide notice of report

Summary:

CCDSS did not provide notification letters to the required adults in a timely manner.

Legal Reference:

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

Action:

CCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:

Failure to provide safe sleep education/information

Summary:

Although CCDSS was in the home and documented safety concerns, safe sleep was not assessed or reviewed with the parents for the SS.

Legal Reference:

13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:

13-OCFS-ADM-02 notes a review and assessment of a child's sleeping environment must be documented, and immediately addressed if assessed to be unsafe. In all CPS investigations with an infant in the home, caregivers must be provided with safe sleep information.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/24/2020	Other Child - 17-year-old child, Female, 17 Years	Grandparent, Male, 45 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Other Child - 17-year-old child, Female, 17 Years	Grandparent, Male, 45 Years	Inadequate Guardianship	Unsubstantiated	



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Other Child - 17-year-old child, Female, 17 Years	Grandparent, Male, 45 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - 17-year-old child, Female, 17 Years	Grandparent, Male, 45 Years	Swelling / Dislocations / Sprains	Unsubstantiated
Other Child - 17-year-old child, Female, 17 Years	Grandparent, Female, 45 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - child of the 17-year-old , Male, 3 Years	Grandparent, Male, 45 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - child of the 17-year-old , Male, 3 Years	Grandparent, Male, 45 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - child of the 17-year-old , Male, 3 Years	Grandparent, Female, 45 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated

Report Summary:

An SCR report alleged the MGF had a history of being physically violent. On 5/24/2020, the MGF tried to choke the father of the 3-year-old child in the presence of the 17-year-old. Two months prior, the MGF stomped on 17-year-old's already fractured foot. As a result, she sustained swelling to the foot, and it turned an abnormal color. The MGF drank alcohol to the point of impairment while caring for the children. On an ongoing basis, the home was in deplorable condition. The floors were covered in garbage and food, and it was hard to move around freely in the home. The home had a foul odor. The MGF and MGM were failing to address the condition of the home.

Report Determination: Unfounded**Date of Determination:** 08/18/2020**Basis for Determination:**

The 17-year-old child reported the MGF did not break her foot or stomp on her foot. There was an altercation that happened between the MGF and the father of the 3-year-old child. A physical altercation occurred when the child's father picked him up from the home and the adults gave several versions of who the aggressor was. The 3-year-old child was not in the home during the incident, he was in a car with the father's friend. The home environment was observed to meet minimal health and safety standards. The case was unfounded and closed.

OCFS Review Results:

SCR history was not reviewed within 1 business day and notification letters were not provided to the required adults timely.

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

Issue:

Review of CPS History

Summary:

A CPS history check was completed untimely. The SCR report was received on 5/24/2020; however, the history check was completed on 8/13/2020.

Legal Reference:

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

Action:

Within one business day, CCDSS will review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded reports where the current report involves a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report. The history check should be documented in progress notes accordingly

Issue:

Failure to provide notice of report

Summary:

The case record reflected that Notice of Existence letters were provided to the required adults late on 8/13/20.

**Legal Reference:**

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

Action:

CCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/12/2020	Sibling, Female, 24 Days	Father, Male, 21 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:

An SCR report alleged the BF engaged in a physical altercation with another adult in the presence of the SS (3-weeks-old at the time). The BF punched, tussled, and had items thrown about the home with the SS present. As a result of engaging in this physical altercation, a television almost fell on top of the SS.

Report Determination: Unfounded

Date of Determination: 03/18/2020

Basis for Determination:

There was an altercation between the BF and another adult the family had been living with. The SM reported she was holding the SS a distance away and the SS was not injured. The other adult was arrested following the incident. There were concerns regarding unstable housing, homelessness, untreated mental health, and past substance misuse. The SM and BF agreed to work with the Department and Preventive Services to address these concerns. The SS was last seen and assessed safe on 3/13/20. The home met minimal standards with no obvious safety hazards seen. The case was opened for Preventive Services.

OCFS Review Results:

CCDSS did not interview the adult involved in the altercation with the BF. SCR history was not reviewed within 1 business day and notification letters were not provided to the required adults timely. CCDSS did not contact collaterals to gather information regarding the BF's drug use and recent arrest and the BF was not referred to substance abuse services. A safety plan was made for the family to reside with the MA; however, CCDSS did not adequately address the family returning to the home of the PGGM which was determined to be unsafe. When the safety plan was not followed and safety concerns remained, CCDSS did not consult with their legal department regarding possible family court action.

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

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

Despite safety factors being identified and a safety plan being devised, the plan was not reflected in the Safety Assessments. CCDSS did not adequately address the safety plan not being followed by the family.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

The results of each safety assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

There were missed opportunities to gather collateral information, such as collaterals regarding the BF's previous substance abuse providers and law enforcement regarding the recent arrest. CCDSS did not interview the adult with whom the altercation occurred or his partner who was in the home during the incident.

Legal Reference:



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

Action:

CCDSS 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 case record reflected that Notice of Existence letters were provided to the required adults late on 3/18/20.

Legal Reference:

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

Action:

CCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report

Issue:

Assessment as to need for Family Court Action

Summary:

There were ongoing concerns for the parents' untreated mental health issues, substance misuse, and homelessness. A safety plan was developed that the family would reside with the MA to mitigate these safety factors. When the parents stopped following the safety plan, CCDSS did not consult with their legal department to assess whether Family Court action was necessary.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:

CCDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:

Failure to Offer Appropriate Services

Summary:

The BF admitted to a history of illegal drug use, and he had a recent arrest for drugs. CCDSS did not offer services or refer the BF for a substance abuse evaluation.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation conducted, CCDSS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

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

From 1997 to 2017, the grandmother had 7 unfounded reports and 11 indicated reports against her, with reported allegations of IG, L/B/W, IF/CS, LMC, SA, CD/AM, and PD/AM.

From 2001 to 2018, the grandfather had 5 unfounded reports and 2 indicated reports against him, with reported allegations of IG and PD/AM.



From 2012 to 2018 the mother had 4 unfounded reports and 3 indicated reports against her, with reported allegations of IG, L/B/W, S/D/S, and LS.

Known CPS History Outside of NYS

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

Preventive Services History

A voluntarily services case was opened on 3/18/20. The family was referred to services for untreated mental health, unstable housing, substance use and a history of poor parenting skills. The family was referred to the services, however, the family was not cooperative and did not engage with the services. The case was closed on 10/29/20.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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