Child Fatality Report

Report Identification Number: BU-20-035

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

Issue Date: Jun 28, 2021

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: 4 month(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 12/30/2020
Initial Date OCFS Notified: 12/30/2020

Presenting Information

Niagara County Department of Social Services (NCDSS) received an SCR report that alleged on 12/30/20, the mother was the sole caretaker for the 4-month-old subject child and five additional children. Some time prior to 10:21PM, the subject child became unresponsive due to traumatic cardiac arrest. Emergency Medical Services was called at 10:21PM by the mother. EMS found the child face down, on the living room floor. He had blood coming from his nose and mouth. The child had visible bruising and swelling to his forehead. He had bruising to his left shoulder, left arm, and to his buttocks. The child also had a depressed left temporal skull fracture and a hematoma. First responders discovered the child with no vitals and completely unresponsive. EMS began lifesaving measures and continued them on the way to the hospital. The child was pronounced deceased at 10:52PM. The injuries were deemed suspicious in nature and the mother had no explanation for the injuries or the death of the child.

Executive Summary

On 12/31/20, the NCDSS received an SCR report regarding the death of the 4-month-old male subject child that had occurred on 12/30/20. The child resided with his mother, grandmother, 16yo aunt, 15yo uncle and 7yo uncle. The father of the subject child was believed to be incarcerated. NCDSS confirmed that no paternity of the subject child had been established through their support collection unit; however, there were no documented attempts to obtain additional information about the father of the child or his whereabouts. The father of the aunt and two uncles did not reside in the home. NCDSS documented attempts to contact him via telephone; however, his whereabouts were unknown and his contact with the aunt and uncles was not clearly documented.

NCDSS coordinated investigative efforts with law enforcement upon receipt of the SCR report. An autopsy was performed; however, the final report was pending the results of the toxicology. The Medical Examiner reported there were no physical findings that would be conclusively suggestive of abuse or maltreatment; however, there were unsafe sleeping conditions. The blood found on child's face, from his mouth and nose was common with unsafe sleep deaths. It was further stated that it was possible that child's pre-existing medical condition was a contributing factor to his death. It was not documented that the Medical Examiner was asked about causation regarding the unsafe sleep conditions and the fatality. In regards to the alleged injuries, the child did have a small bump below his hairline from the shunt placed in his head about one month prior to death. The marks that appeared to be bruises on the child's shoulders were blood pooling. The mark that appeared to be a bruise on child's buttocks was thought to be a Mongolian spot. Bruising was ruled out as there was no hemorrhaging below the skin. The Medical Examiner stated that the autopsy examination showed no signs of trauma and that the preliminary cause and manner of death were undetermined. The law enforcement investigation did not reveal any criminality and their case closed.

The mother reported the night of the fatality around 8:00PM, she and the subject child were laying down in her bed watching television. The child was giggling and happy as he laid next to her. The mother stated that they laid in bed until the child fell asleep. The mother stayed awake and reported she looked over at the child as he slept peacefully. The mother reported when she looked at the child later on, she saw blood on his face, by his nose and mouth and he was unresponsive. The mother attempted to revive the child and called 911. First responders arrived and transported the infant to the hospital via ambulance. Resuscitative measures were unsuccessful, and the child was pronounced deceased at 10:25 PM.

The allegations of Internal Injuries, Lacerations/Bruises/Welts and Fractures and Swelling/Dislocations/Sprains were unsubstantiated against the mother and grandmother regarding the subject child due to the findings of the autopsy

examination. Allegations of DOA/Fatality and Inadequate Guardianship were unsubstantiated due to a lack of credible evidence that the mother and grandmother's actions caused the child's death or that they failed to provide a minimum level of care for the child. The family was referred for counseling services and funeral assistance and the investigation was closed on 3/4/21.

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?** No
  - **Safety assessment due at the time of determination?** No
- **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. Although there was face-to-face contact made with the mother and surviving children, the interviews did not contain questions about overall safety and risk.

Was the decision to close the case appropriate? Yes

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 case record does not reflect that the safety of the surviving children was adequately assessed. Interviews with the children and mother were focused on the fatality and did not reflect overall safety and risk topics were addressed.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	Although NCDSS documented interviews with the mother and surviving children regarding the fatality, the interviews did not contain questions to assess overall safety and risk.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)

Action:	NCDSS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	NCDSS inquired with their child support unit regarding paternity of the subject child and determined it had not been established; however, NCDSS did not document that they asked the mother about the father or made additional efforts to contact him.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	NCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/30/2020 **Time of Death:** 10:52 PM

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

County where fatality incident occurred: Niagara
Was 911 or local emergency number called? Yes
Time of Call: 10:21 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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? 2 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	Aunt/Uncle	No Role	Female	16 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	15 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	7 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	41 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Other Household 1	Other Adult - Father of the 16yo aunt, 15yo uncle and 7yo uncle	No Role	Male	39 Year(s)

LDSS Response

NCDSS investigated the incident by searching SCR history and speaking to the source of the report, the SM, MGM and surviving children. They made collateral contacts with LE, EMS, the ME and the pediatrician.

During interviews with the SM she stated that the morning of the fatality she went and got her hair done and left the SC at home with her family. The SM came home afterward and spent the next few hours at home with her family and the SC. The SM reported the SC acted, slept and ate normally during the day. In the evening, the SM and MGM left the home to go shopping and left the SC in the care of the 16yo aunt. The SM stated that when she and the MGM got home, there were no concerns with the children. The SC acted and ate normally and the SM changed his diaper. The SM reported laying down with the SC in her king sized bed around 8:00PM and they watched television. The SC fell asleep and the SM stayed awake and was on her phone for some time. The SM reported looking at the SC sleeping peacefully and then looking back at SC again later on, and seeing blood on his face, by his nose and mouth. The SM began panicking and yelled for the MGM. The SM picked the SC up and reported that his body felt limp. The SM stated that she knew in that moment that he was not alive. The SM carried the SC downstairs, laid him on the living room floor and attempted to revive him. First responders arrived and took over life saving efforts, which continued as they transported the SC to the hospital via ambulance.

The MGM's accounts of the events leading up to the fatality were consistent with the SM's. The MGM reported the SM took the SC to bed at 8:00PM and she did not hear from the SM until 10:00PM, when she was screaming for help and brought the SC downstairs. The MGM further stated that she did not suspect anyone in the home to harm the SC and she believed his underlying medical condition may have contributed to his heart stopping.

The 16yo aunt and 15yo uncle were interviewed at the home. The 15yo reported he was home and asleep when he was woken up by the SM screaming. He went downstairs and saw the SC deceased on the living room floor. The 16yo cared for the child the day of the fatality and reported no concerns for him. As the 16yo was watching the SC, she noticed he was really warm with his covers on, so she waved her hand in front of his face to try and cool him off. The SM got home and took the SC into her room and the SM and SC were laying on the SM’s bed. The 16yo reported that she walked by the bedroom a few times and saw the SM and SC laying on the bed. The SM was laying on the left side on the bed closer to the wall and the SC was on the other side. The 16yo reported at an unknown time that she heard what she thought was a thump and then another, but was not sure if it was noise coming from her neighbor’s house. The 16yo thought it might

have been the SC falling off the bed. The 16yo walked by the bedroom again and did not think she saw the SC on the bed, but the SM was still laying on the bed, so she didn't think that the SC fell because the SM would not have still been laying there. It was not documented that the 16yo was asked if she observed the mother to be asleep when she walked by after hearing the thump noise.

Following the incident, the SC's medical history was reviewed and it was learned that the SC had a genetic syndrome. The SC was on various medications and had services in place. First responders reported that they were told by the family that the SC was not expected to live past 3-months-old. In addition, first responders reported the SM provided a different account of events regarding the incident, stating that she had fallen asleep with the SC and found him on the floor next to the bed. Hospital records showed that the SM also reported she had fallen asleep with the SC and woke up to find him with blood coming from his nose, but denied that the SC had fallen or was injured.

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
Comments: NCDSS met with law enforcement, the District Attorney, and CAC staff on the day they were notified of the fatality and collaborated investigative efforts.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057221 - Deceased Child, Male, 4 Mons	057222 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
057221 - Deceased Child, Male, 4 Mons	057222 - Mother, Female, 20 Year(s)	Fractures	Unsubstantiated
057221 - Deceased Child, Male, 4 Mons	057222 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Unsubstantiated
057221 - Deceased Child, Male, 4 Mons	057222 - Mother, Female, 20 Year(s)	Internal Injuries	Unsubstantiated
057221 - Deceased Child, Male, 4 Mons	057222 - Mother, Female, 20 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
057221 - Deceased Child, Male, 4 Mons	057223 - Grandparent, Female, 41 Year(s)	DOA / Fatality	Unsubstantiated
057221 - Deceased Child, Male, 4 Mons	057223 - Grandparent, Female, 41 Year(s)	Fractures	Unsubstantiated
057221 - Deceased Child, Male, 4 Mons	057223 - Grandparent, Female, 41 Year(s)	Inadequate Guardianship	Unsubstantiated
057221 - Deceased Child, Male, 4 Mons	057223 - Grandparent, Female, 41 Year(s)	Internal Injuries	Unsubstantiated

057221 - Deceased Child, Male, 4 Mons	057223 - Grandparent, Female, 41 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
057221 - Deceased Child, Male, 4 Mons	057222 - Mother, Female, 20 Year(s)	Swelling / Dislocations / Sprains	Unsubstantiated

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:
There were two attempted phone calls documented with the father of the aunt and two uncles.

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 assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☒	☐	☐
At 7 days?	☐	☒	☐	☐
At 30 days?	☐	☒	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐
Explain: Although NCDSS documented interviews with the surviving children, the interviews were focused on the allegations and did not include questions about overall safety and risk.				

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	☐	☐	☐	☒
Explain: The mother was identified as the primary caretaker of the children in the Risk Assessment Profile and it was not documented that she was asked questions regarding risk factors.				

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

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

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 discussed counseling services with the 16yo aunt and 15yo uncle and provided mental health resources to the grandmother on behalf of the children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was offered funeral assistance and mental health counseling. It was unknown if she accepted the services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
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)
02/11/2019	Aunt/Uncle, Female, 14 Years	Grandparent, Female, 39 Years	Educational Neglect	Substantiated	Yes
	Aunt/Uncle, Female, 14 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Substantiated	
	Aunt/Uncle, Female, 14 Years	Other Adult - Father of 14yo aunt, 13yo uncle and 5yo uncle, Male, 37 Years	Educational Neglect	Substantiated	
	Aunt/Uncle, Female, 14 Years	Other Adult - Father of 14yo aunt, 13yo uncle and 5yo uncle, Male, 37 Years	Inadequate Guardianship	Substantiated	

Report Summary:
NCDSS received an SCR report that alleged during the 2018-2019 school year, the then 14yo aunt had missed 37 days of school. The grandmother and aunt's father were made aware of the situation but were not been able to address the issue. As a result, the aunt continued to be absent and was failing all her classes. She was also missing school based services.

Report Determination: Indicated **Date of Determination:** 05/24/2019

Basis for Determination:
The allegations of Educational Neglect and Inadequate Guardianship were substantiated. It was determined during the investigation that the 14yo aunt had an IEP and needed to be in school every day to receive her services in order to be successful at school. The aunt had missed 37 days of school and during the CPS investigation missed an additional 12 days and was failing three subjects.

OCFS Review Results:
NCDSS completed home visits, spoke to a collateral and documented a CPS history check. It was not documented that the children were interviewed. The record did not reflect that efforts were made to speak to the source of the SCR report. The grandmother and father of the children were not interviewed about overall safety and risk. There was no supervisory consultation documented throughout the investigation.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
It was not documented that there were efforts made to speak to the source of the SCR report.

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

Action:

NCDSS will contact, or make diligent efforts to contact, the source of all SCR reports so as to verify adequacy of report and possibly receive additional information.

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
The case was pre-determined to the assessment of safety and risk. It was not documented that there were interviews completed with the children or that the grandmother and father of the aunt and uncles were interviewed regarding overall safety and risk.

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

Action:
NCDSS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

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

Summary:
Although the children were seen throughout the investigation, it was not documented that they were interviewed regarding the concerns identified in the SCR report and overall safety and risk. In addition, the interviews with the grandmother and the father of the aunt and uncles were focused on the allegations and did not include questions regarding overall safety and risk.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
NCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/27/2018	Aunt/Uncle, Male, 13 Years	Grandparent, Female, 39 Years	Other	Substantiated	Yes
	Aunt/Uncle, Male, 13 Years	Other Adult - Father of 14yo aunt, 13yo uncle and 5yo uncle, Male, 37 Years	Other	Substantiated	

Report Summary:
Niagara County Family Court ordered a court ordered investigation regarding concerns that the then 13yo uncle was not going to school and was not receiving an adequate education. In addition, there were concerns about the 13yo uncle running away from home.

Report Determination: Indicated **Date of Determination:** 08/27/2018

Basis for Determination:
The allegation of OTH/COI against the grandmother and the 13yo uncle's father was substantiated. NCDSS determined that the 13yo uncle was often absent 1 to 2 times a week and therefore his grades were very low. NCDSS filed a Neglect Petition and the family was opened to preventive services.

OCFS Review Results:
NCDSS completed home visits, made referrals for appropriate services and documented a CPS history check. It was not

documented that the then 14yo aunt and 5yo uncle were interviewed. A service provider documented that the mother resided in the home; however, she was not interviewed, added to the investigation or notified of the SCR report in writing. It was not documented that efforts were made to speak to the source of the SCR report.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
It was not documented that there were efforts made to contact the source of the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
NCDSS will contact, or make diligent efforts to contact, the source of all SCR reports so as to verify adequacy of report and possibly receive additional information.

Issue:
Failure to provide notice of report
Summary:
A service provider visited the home and documented that the mother resided in the residence; however, she was not added to the investigation or notified of the SCR report in writing.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
NCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The record did not reflect that the then 14yo aunt and 5yo uncle were interviewed.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
NCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the length of the investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/06/2018	Mother, Female, 17 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Mother, Female, 17 Years	Grandparent, Male, 47 Years	Inadequate Guardianship	Unsubstantiated	
	Mother, Female, 17 Years	Other Adult - Step grandmother , Female, 37 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
NCDSS received an SCR report which alleged that 3 years ago, the grandfather and step grandmother kicked the mother out of the house without making any plans for her care. The grandfather and step grandmother would not allow the

mother to return home. The grandmother was aware of the situation but did nothing to intervene and help the mother. As a result the child had been homeless bouncing from place to place for the last 3 years. The mother was in need of a shelter and other essential provisions.

Report Determination: Unfounded | **Date of Determination:** 10/24/2018

Basis for Determination:
NCDSS unsubstantiated the allegations of Inadequate Guardianship regarding the mother. The grandparents and step grandmother were interviewed an denied kicking the mother out of their homes. They reported the mother left their homes because she didn't like to follow rules. The mother admitted to not following any house rules.

OCFS Review Results:
NCDSS completed home visits, spoke to the source, offered appropriate community services to the mother and documented a CPS history check. NCDSS did not document face-to-face contact with the grandmother. The interviews with the grandfather and step grandmother were allegation focused and did not include questions about overall safety and risk. The mother's interview did not contain questions regarding the SCR report and overall safety and risk. Several of the progress notes were not entered contemporaneously with their event dates. The grandmother had two other children, who were not assessed for safety. There was no supervisory consultation documented throughout the investigation.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Approximately 6 out of 12 progress notes were entered more than a month after their event dates.
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:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
There was face-to-face contact with the grandfather and step grandmother; however, the interviews with them did not contain questions about overall safety and risk.The grandmother had two other children living in her home who were not seen or interviewed.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
NCDSS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
NCDSS conducted phone calls with the grandmother; however, there were no efforts documented to interview her face-to-face.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
Although NCDSS interviewed the mother face-to-face, the allegations were not explored and she was not asked questions about overall safety and risk.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
NCDSS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/06/2018	Mother, Female, 17 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Mother, Female, 17 Years	Grandparent, Male, 47 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
NCDSS received an SCR report which alleged that in mid January 2018, the grandfather kicked the mother out of the home without making a plan for her care. After staying with a couple of other family members, the mother went to the home of the grandmother in mid February. The mother was threatening and disrespecting the grandmother and had a behavior problem. The grandmother was afraid of the mother and was not able to care for her or make another plan for her care.

Report Determination: Unfounded | **Date of Determination:** 10/22/2018

Basis for Determination:
The allegation of Inadequate Guardianship against the grandparents was unsubstantiated. NCDSS interviewed the grandfather and mother and they both denied that the grandfather kicked the mother out of his home. The mother admitted to not following any house rules. The mother was living with her paternal grandmother and working full time at the closure of the investigation.

OCFS Review Results:
NCDSS completed home visits, mailed notice of the report in writing within required time frames, offered appropriate community services to the mother and documented a CPS history check. NCDSS documented face-to-face contact with the mother and grandparents. The grandmother was not interviewed and the grandfather and mother's interview were allegation focused and did not include questions about overall safety and risk. Several of the progress notes were not entered contemporaneously with their event dates. The grandmother had two other children, who were not assessed for safety. There was no supervisory consultation documented throughout the investigation.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
There was face-to-face contact with the grandmother; however, she was not interviewed. The grandmother had two other children living in her home who were not seen or interviewed. The interviews with the grandfather and mother did not contain questions about overall safety and risk.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:

NCDSS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Approximately 13 out of 20 progress notes were entered more than a month after their event dates.
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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/05/2018	Aunt/Uncle, Male, 12 Years	Grandparent, Female, 38 Years	Educational Neglect	Unsubstantiated	Yes
	Aunt/Uncle, Male, 12 Years	Grandparent, Female, 38 Years	Other	Unsubstantiated	
	Aunt/Uncle, Male, 12 Years	Other Adult - Father of the then 12yo uncle, Male, 36 Years	Educational Neglect	Unsubstantiated	
	Aunt/Uncle, Male, 12 Years	Other Adult - Father of the then 12yo uncle, Male, 36 Years	Other	Unsubstantiated	

Report Summary:
Niagara County Family Court issued a court ordered investigation. It was alleged that the then 12yo uncle had missed 27 days of school since 2/1/18. The uncle was failing and had no grades. The grandmother and father of the uncle were aware and failed to ensure the child was attending school regularly.

Report Determination: Unfounded | **Date of Determination:** 04/18/2018

Basis for Determination:
NCDSS unsubstantiated the allegations of Educational Neglect and Other (Court Ordered Investigation) against the grandmother and father of the then 12yo uncle. NCDSS wrote in their investigation conclusion narrative that at the end of the investigation, the 12yo uncle was attending home schooling and was engaged in mental health counseling. There was also an open PINS case for the 12yo.

OCFS Review Results:
NCDSS contacted the source or the SCR report, documented a CPS history check, spoke to an appropriate collateral and assessed for safety of the 12yo uncle within 24 hours of receipt of the SCR report. The interviews documented with the grandmother and father of the 12yo uncle were focused on the allegations of the SCR report and did not include questions about overall safety and risk. The 12yo uncle had two siblings who resided in the home, and they were not interviewed and assessed for safety. The notification letters were not provided within required timeframes.

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

Issue:
Failure to provide notice of report
Summary:
The notification of existence letters were provided late on 3/26/18.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
NCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
NCDSS documented face-to-face interviews with the then 12yo uncle, father of the uncle and the grandmother; however, the interviews were focused on the allegations and did not contain questions about overall safety and risk. In addition, there were 2 other children residing in the home who were not interviewed or assessed for safety.

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

Action:
NCDSS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

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

Between 2005 and 2017, the father of the 16yo aunt, 15yo uncle and 7yo uncle had 3 indicated CPS investigations. The substantiated allegations included IG, LS, CD/A, EdN and LMC and were regarding the mother, aunt and uncle.

In 2017, the grandmother had 2 indicated CPS investigations and 1 unfounded CPS investigation. The substantiated allegations included IG, LS, CD/A, LMC and EdN and were regarding the 15yo uncle. The unsubstantiated allegations included EdN, IG, LMC and PD/AM and were regarding the mother, aunt and uncle.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

The grandmother had an open Preventive Services Case, which opened on 3/14/19 due to concerns about the 15yo uncle's attendance at school. In addition, there were concerns with the grandmother's mental health. NCDSS filed a Neglect Petition and offered case management services, parent training services, mental health counseling referrals, child preventive services, and child safety information. The case was closed on 11/13/19 and it was unclear from the record what the results of the Neglect Petition were. At case closure, NCDSS wrote that the uncle was attending school and the grandmother reported no concerns for his behaviors in the home. The children were receiveing appropriate medical care and NCDSS determined that there had not been any obvious signs of abuse or maltreatment.

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