Child Fatality Report

Report Identification Number: BU-22-009

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

Issue Date: Nov 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	DA-District Attorney	
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	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Chautauqua
Gender: Female
Date of Death: 06/05/2022
Initial Date OCFS Notified: 06/05/2022

Presenting Information

Chautauqua County Department of Health and Human Services (CCDHHS) received three SCR reports on 6/3/22 and a fourth SCR report on 6/5/22, that alleged the subject child was placed to sleep on an adult bed and was left unsupervised. The parents checked on the child a short time later, and the child was found face down between a pile of bags and clothes and was unresponsive. Two nearby utility workers went over to the home, called 911, and performed CPR until first responders arrived. Emergency Medical Services (EMS) took over resuscitative measures and transported the child to the hospital. While at the hospital it was determined the child needed a higher level of care and was airlifted to another hospital. The child's brain was not functioning, and the parents elected to terminate medical support and the child was pronounced deceased at 12:37AM on 6/5/22.

Executive Summary

This fatality report concerns the death of a 4-month-old female subject child that occurred on 6/5/22. The fatal incident that led to the child's death occurred on 6/3/22. At the time of the child's death, she resided with her mother, father, paternal grandmother, and paternal uncle. There were no surviving siblings. At the time of the fatal incident the child was at home with her parents and paternal uncle. The paternal grandmother was not at home.

The investigation revealed that the paternal grandmother had an open CPS investigation at the time of the incident, which began on 5/31/22. During a home visit on the morning of 6/3/22, CCDHHS provided the family with a portable crib for the child. Later that night, the mother placed the child to sleep on the parents' bed, on a Boppy Pillow, and left the child unattended for about thirty minutes. The father went to check on the child and could not find her. The mother found the child amongst several garbage bags that were filled with clothing, between the bed and a wall. The child was unresponsive, and the father attempted cardiopulmonary resuscitation, but was unsuccessful and carried the child outside. Two utility workers that were working nearby, called 911, and began cardiopulmonary resuscitation on the child until first responders arrived at the residence. The child was transported to the hospital by EMS and upon arrival the child was in respiratory and cardiac arrest. Hospital staff continued life saving measures and obtained a pulse on the child. The child was airlifted to another hospital, placed on a ventilator, and had very low brain activity. The child was taken off life support at the parents' request and the child was pronounced deceased on 6/5/22.

An Autopsy was performed, and the final report was pending at the time this report was written. CCDHHS spoke with the medical examiner and there were no visible signs of trauma. The medical examiner reported that unsafe sleep practices may have played a role as an extrinsic factor in the child's death. Law enforcement investigated the incident, and no criminal charges were filed at the writing of this report; however, the criminal case remained open pending the findings of the autopsy and toxicology reports.

CCDHHS interviewed all household members, and they contacted relevant collaterals. CCDHHS substantiated the allegations of Inadequate Guardianship, Lack of supervision, and DOA/Fatality against the mother and the father. The parents had access to safe sleep for the child and they failed to place the child in a safe sleep environment and left the child unsupervised for an undetermined amount of time. The allegation of Inadequate Food, Clothing and Shelter against the paternal grandmother was substantiated. The parents and child resided with the paternal grandmother, she was aware of the living environment and failed to take corrective action. The allegations against the paternal uncle were unsubstantiated, since it was determined he was not a person legally responsible for the subject child. At the onset of the

investigation the uncle was 17-years-old and assessed to be safe in the home; he turned 18 during the investigation. CCDHHS referred the family to services and closed the case. It was unknown if the family engaged in the services.

PIP Requirement

CCDHHS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the CCDHHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDHHS 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:

The decision to close the case was appropriate.

Was the decision to close the case appropriate? Yes

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

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

Explain:

Casework contacts were completed timely and relevant collaterals were contacted. Notice of Existence letters were provided in a timely manner.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/05/2022 **Time of Death:** 12:37 AM

Date of fatal incident, if different than date of death: 06/03/2022
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: 02:50 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

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	Alleged Perpetrator	Male	17 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	19 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)

LDSS Response

CCDHHS began their investigation into the child's death on 6/3/22, upon receipt of the three SCR reports regarding the fatal incident and the SCR report received on 6/5/22 regarding the death of the child. CCDHHS completed a history check and spoke to sources of the reports, hospital staff, law enforcement, the District Attorney's office, and the medical examiner. Throughout the investigation, CCDHHS conducted home visits, interviewed all household members, and reviewed records from the hospital, Emergency Medical Services, law enforcement, and the pediatrician.

Through interviews with family members, it was learned that CCDHHS dropped off two portable cribs to the residence on the morning of 6/3/22 and discussed safe sleep guidelines with the parents. One portable crib was set up in the living room and the other in the parents' bedroom. The parents were interviewed following the fatality, and reported they used the portable crib in the living room during the day for the child; however, the mother stated the child also regularly slept in the bed with her and the father. When co-sleeping, the child was placed in the middle of the parents, elevated with a Boppy Pillow, and covered with a blanket up to her stomach. The night of the fatal incident, the mother changed and fed the child on the bed and then left her on the bed to sleep. The parents were watching television in the living room and the father went to check on the child and was unable to find her. The child was found unresponsive amongst several garbage bags, clothes and a bicycle that were between the bed and the wall. The paternal uncle reported he was upstairs in his room and

was unaware of what happened to the child and was told to call 911 by the father. The paternal grandmother was at work when the fatal incident occurred.

CCDHHS assessed the condition of the home, as it was reported to be a concern in one of the reports made to the SCR regarding the fatal incident and death. CCDHHS found the home was cluttered, but there were clear pathways to move about. Although the paternal grandmother was at work when the fatal incident happened, she was aware of the condition of the home, specifically the items near the bed which created a safety hazard for the child. The grandmother had minor children who frequented the home; therefore, CCDHHS addressed the conditions that were of concern and the condition was found to be safe at case closure.

The pediatrician was contacted by CCDHHS, and the child was found to be an otherwise healthy child and no concerns were reported. Although the child was born with a positive toxicology there were no concerns regarding the mothers' drug use. The mother had diagnosed mental health, and reported she was not in any treatment and was not taking any medication.

CCDHHS indicated and closed the case. The mother requested grief counseling and the family was given a resource list and referred to community-based services. It was unknown at the close of the investigation if the family engaged in the services.

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: Chautauqua County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061783 - Deceased Child, Female, 4 Mons	061784 - Mother, Female, 20 Year(s)	DOA / Fatality	Substantiated
061783 - Deceased Child, Female, 4 Mons	061784 - Mother, Female, 20 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
061783 - Deceased Child, Female, 4 Mons	061784 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
061783 - Deceased Child, Female, 4 Mons	061784 - Mother, Female, 20 Year(s)	Internal Injuries	Unsubstantiated
061783 - Deceased Child, Female, 4 Mons	061784 - Mother, Female, 20 Year(s)	Lack of Supervision	Substantiated
061783 - Deceased Child, Female, 4 Mons	061785 - Father, Male, 19 Year(s)	DOA / Fatality	Substantiated

061783 - Deceased Child, Female, 4 Mons	061785 - Father, Male, 19 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
061783 - Deceased Child, Female, 4 Mons	061785 - Father, Male, 19 Year(s)	Inadequate Guardianship	Substantiated
061783 - Deceased Child, Female, 4 Mons	061785 - Father, Male, 19 Year(s)	Internal Injuries	Unsubstantiated
061783 - Deceased Child, Female, 4 Mons	061785 - Father, Male, 19 Year(s)	Lack of Supervision	Substantiated
061783 - Deceased Child, Female, 4 Mons	061786 - Grandparent, Female, 43 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
061783 - Deceased Child, Female, 4 Mons	061786 - Grandparent, Female, 43 Year(s)	Inadequate Guardianship	Unsubstantiated
061783 - Deceased Child, Female, 4 Mons	061786 - Grandparent, Female, 43 Year(s)	Lack of Supervision	Unsubstantiated
061783 - Deceased Child, Female, 4 Mons	061787 - Aunt/Uncle, Male, 17 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
061783 - Deceased Child, Female, 4 Mons	061787 - Aunt/Uncle, Male, 17 Year(s)	Inadequate Guardianship	Unsubstantiated
061783 - Deceased Child, Female, 4 Mons	061787 - Aunt/Uncle, Male, 17 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine

Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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? No
Explain:
There were no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:
CCDHHS provided the family with a referral for grief 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?	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)
05/31/2022	Aunt/Uncle, Female, 16 Years	Grandparent, Female, 43 Years	Educational Neglect	Unsubstantiated	Yes
	Aunt/Uncle, Female, 16 Years	Grandparent, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The paternal aunt (PA) was absent 83 days the 2021-2022 school year. She was consecutively absent the last 18 out of 83 reported school days. The PA had an IEP and was missing services. As a result of the PA's lacking attendance, her education was negatively affected. The paternal grandmother (PGM) was aware of the attendance problem but failed to address it.

Report Determination: Unfounded | **Date of Determination:** 06/29/2022

Basis for Determination:
At the time of the report the PA was not residing in the PGM's home. The PGM and her home were available to the PA whenever needed. The PA had young children, and the PGM reported many of the PA's absences were due to the PA having to care for them. The PGM made efforts to get the PA to school. The PGM worked with community-based

services to ensure that the PA and her children's needs were met, and the PA's educational needs were explored. The allegations of IG and EdN were unsubstantiated, and the case was closed.

OCFS Review Results:
CCDHHS checked history, made home visits, conducted interviews, and assessed the safety of the children. Safety assessments were appropriate and progress notes were entered on time; however, CCDHHS did not send notification letters to adults in the required time frame and did not follow up with the school regarding the PA's attendance.

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

Issue:
Failure to provide notice of report

Summary:
CCDHHS did not provide notification letters to the adults on the report within the required time frame. CCDHHS received the report on 5/31/22 and the letters were sent on 6/28/22.

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

Action:
CCDHHS 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)
05/31/2022	Aunt/Uncle, Female, 16 Years	Grandparent, Female, 43 Years	Childs Drug / Alcohol Use	Unsubstantiated	Yes
	Aunt/Uncle, Female, 16 Years	Grandparent, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	
	Aunt/Uncle, Female, 16 Years	Grandparent, Female, 43 Years	Sexual Abuse	Unsubstantiated	

Report Summary:
The PGM was aware the 16-year-old PA had sexual intercourse with her adult boyfriend that resulted in the birth of two children. The PGM allowed the PA to reside with the boyfriend and there were concerns of drug use and domestic violence. The PGM was aware of these concerns and failed to intervene.

Report Determination: Unfounded **Date of Determination:** 06/29/2022

Basis for Determination:
The PA was not residing in the PGM's home, she was living on her own raising her two children. The PGM and her home were available to the PA and her children whenever needed. The MGM did not condone the PA's sexual relationship nor allowed it to happen in her home. There was no evidence the PA used drugs or that the PGM allowed the PA to use drugs. The PA appeared sober and coherent at all visits. The was no evidence of DV between the PA and her boyfriend and both denied that any DV occurred. The PA's children were seen, and safe sleep was observed for both children. The family was offered services and declined. The case was unfounded, closed and referred to community-based services.

OCFS Review Results:
CCDHHS checked history, made home visits, conducted interviews, and assessed the safety of the children. Safety assessments were appropriate and progress notes were entered on time; however, CCDHHS did not send notification letters to adults in the required time frame. CCDHHS did not make a law enforcement referral regarding the alleged sexual abuse. CCDHHS did speak with LE that were at the PA's home on 5/31/22, regarding the report. LE reported no concerns and stated everything was consensual.

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

Issue:
Failure to provide notice of report

Summary:
CCDHHS did not provide notification letters to the adults on the report in the required time frame. CCDHHS received the report on 5/31/22 and the letters were sent on 6/28/22.

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

Action:
CCDHHS 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.

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/16/2022	Deceased Child, Female, 1 Days	Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:
The mother delivered the subject child and both the mother and the child tested positive for marijuana. The father resided in the home and had an unknown role.

Report Determination: Unfounded **Date of Determination:** 02/11/2022

Basis for Determination:
CCDHHS completed the investigation and determined there was no negative impact on the child regarding the positive toxicology. The mother agreed to work with services and CCDHHS submitted a referral for services. Due to lack of fair preponderance of evidence the report was unfounded, and the case closed.

OCFS Review Results:
CCDHHS did not complete a plan of safe care for the mother and subject child regarding the positive toxicology of substances. NOE letters were not mailed within the required time frame to the required adults. CCDHHS completed home visits, safe sleep was observed for all the children and safe sleep guidance was reviewed with all household members. A referral was made for services and the mother was given phone numbers for counseling.

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

Issue:
Failure to complete, document, and monitor a Plan of Safe Care

Summary:
CCDHHS failed to develop, document & monitor a Plan of Safe Care to address the health and substance use disorder treatment needs of both the infant and affected caregiver despite knowledge the infant was identified as being born exposed to substances.

Legal Reference:
17-OCFS-LCM-03 & 18-OCFS-LCM-06

Action:
CCDHHS will complete, document & monitor a Plan of Safe Care that specifically addresses the child(ren) affected by substance misuse and the affected caregiver. CCDHHS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

Issue:
Failure to provide notice of report

Summary:
CCDHHS did not send Notice of Existence letters to the required adults within the required time frame.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
CCDHHS 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)
08/25/2020	Aunt/Uncle, Male, 16 Years	Grandparent, Female, 41 Years	Educational Neglect	Unsubstantiated	Yes
	Unrelated Home Member, Female, 15 Years	Grandparent, Female, 41 Years	Educational Neglect	Unsubstantiated	
	Other Child - cousin, Female, 1 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 1 Years	Grandparent, Female, 41 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Other Child - cousin, Female, 1 Years	Aunt/Uncle, Female, 15 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 1 Years	Aunt/Uncle, Female, 15 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Other Child - cousin, Female, 1 Months	Grandparent, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 1 Months	Grandparent, Female, 41 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Other Child - cousin, Female, 1 Months	Aunt/Uncle, Female, 15 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 1 Months	Aunt/Uncle, Female, 15 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The infant cousin had bruises all over her head and legs. The 1-year-old cousin had a black and blue palm print on her back. The PA and the PGM had no explanation for how the children sustained the injuries. A subsequent report was received that alleged the PU missed 19 out of 21 school days, the unrelated home member missed 17 school days, and both were failing as a result. The PGM failed to address the concerns.

Report Determination: Unfounded | **Date of Determination:** 12/14/2020

Basis for Determination:
CCDHHS observed the infant and 1-year-old cousin. The children had no marks or bruises and photos were taken to verify no injuries. The pediatrician was contacted and had no concerns for the children. The PU and the unrelated home member were not attending their virtual classes. The PGM was in contact with the school staff and was working with the school regarding the concerns. A school PINS was filed for the unrelated home member and the PU. There was no credible evidence to support the allegations and the case was unfounded and closed.

OCFS Review Results:
CCDHHS made home visits, conducted interviews with the family and spoke with collaterals. The record did not reflect that history was checked or documented within the required time frame.

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

Issue:
Review of CPS History

Summary:
CCDHHS did not complete or document history in the required time frame.

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/02/2020	Father, Male, 17 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Aunt/Uncle, Male, 15 Years	Grandparent, Female, 41 Years	Educational Neglect	Unsubstantiated	
	Aunt/Uncle, Male, 15 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Aunt/Uncle, Female, 14 Years	Grandparent, Female, 41 Years	Educational Neglect	Unsubstantiated	
	Aunt/Uncle, Female, 14 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 5 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Unrelated Home Member, Female, 15 Years	Grandparent, Female, 41 Years	Educational Neglect	Unsubstantiated	
	Unrelated Home Member, Female, 15 Years	Grandparent, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 8 Months	Grandparent, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The PU missed 49 days of school and was failing as a result. The 15-year-old unrelated home member missed 42 days of school and was failing as a result. The PA missed 21 days of school and was failing as a result. The PGM allowed an adult male to reside in the home that had a history of violent behaviors. The PGM was aware of the concerns and failed to address them.

Report Determination: Unfounded | **Date of Determination:** 05/13/2020

Basis for Determination:
The PU was suspended from school and was attending an alternative education program. The PU returned to school after the suspension was over. The PA was attending school and the PGM enrolled the unrelated home member in school and

filed for custody in family court. Due to the COVID-19 pandemic, all children were doing online learning. The children did not express fear or concerns regarding the adult male being in the home. The PGM reported she had no concerns for the behavior of the adult male. There was no credible evidence to support the allegations and the report was unfounded and closed.

OCFS Review Results:
CCDHHS made home visits, assessed the safety of all the children, and submitted the safety assessment on time.
CCDHHS did not document a check history or send Notice of Existence letters in the required time frame.

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

Issue:
Failure to provide notice of report
Summary:
CCDHHS 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:
CCDHHS 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:
Review of CPS History
Summary:
CCDHHS did not complete or document a history check in the required time frame. The SCR report was received on 3/2/20; however, the history check was not completed until 5/12/20.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, CCDHHS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, CCDHHS will review all CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

[redacted]

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

The father had no CPS history more than years prior to the fatality. The mother had no CPS history more than years prior to the fatality. Between 2002 and 2019, the PGM had 31 SCR reports against her. Of the 32, 21 of them were indicated for allegations of EdN, CD/A, IG, LS, LMC, and IF/C/S.

Known CPS History Outside of NYS

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

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.

Additional Local District Comments

Chautauqua County agrees with the findings in the case history review with this family. It appears that staff did address safe sleep with the family, but the family failed to use the provided resources, leading to an unsafe situation for the child.

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