Child Fatality Report

Report Identification Number: AL-19-011

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

Issue Date: Aug 15, 2019

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☒ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Albany
Gender: Male
Date of Death: 03/05/2019
Initial Date OCFS Notified: 03/05/2019

Presenting Information

An SCR report alleged on 3/5/19, around 1:00 AM, the grandmother found the 6-month-old male subject child unresponsive in his bassinet, with a blanket. The grandmother put the child down to sleep only moments before finding him in that condition. It was unknown if the blanket covered the child's face at any time. There were no known visible injuries to the child and there was no mention of any pre-existing condition that would have caused the child's condition. The mother and grandmother were the only caretakers for the child. The grandmother called for help from emergency services. CPR was performed and the child was transported to the hospital. The child was pronounced deceased on 3/5/19. There were other children in the home, but their identities were unknown.

Executive Summary

This fatality report concerns the death of a six-month-old male subject child (SC) that occurred on 3/5/19. A report was made to the SCR on the same day regarding concerns the child had no known medical condition that would have caused the child's death. There were five surviving siblings, aged 2, 6, 9, 12 and 17 years. The four youngest siblings were assessed to be safe in the care of their maternal grandmother within the first 24 hours of the investigation. Although a 17-year-old sibling was listed on the case composition, he had not been a resident of the household for the past year and was in a local county jail in the custody of the criminal court system.

Albany County Department for Children, Youth and Families (ACDCYF) documented the Albany Police Department was investigating the death and had taken bedding found in the child's bassinet into evidence. The 24-hour Fatality Report contained information that ACDCYF notified the District Attorney and Coroner's Office of the death. An autopsy performed showed no signs of trauma. The child's organs appeared unremarkable and showed no signs of illness. The final autopsy report was not available at the time this report was written. The cause and manner of death were pending further studies.

The mother reported placing the child in his bassinet after feeding him around 10:00 PM. She checked on the child several times, and then found him unresponsive with "pink stuff" coming from his nose. 911 was called and the mother performed CPR until EMS arrived. First responders arrived at the home approximately five minutes later and transported the child to the hospital. Resuscitative efforts were unsuccessful and the child was pronounced deceased at 2:25 AM.

ACDCYF collected information from first responders, including fire fighters, paramedics and doctors. The parents were interviewed, as well as the maternal grandmother, who were unable to provide an explanation for the child's death.

Home visits were conducted during the investigation and no safety concerns were noted. Grief counseling, burial assistance and Wave Riders (a program to assist families through traumatic experiences), were offered to the family. ACDCYF completed the 24-hour Fatality Report and 24-hour Safety Assessment timely and accurately. Although the 7-day Safety Assessment was completed timely, there was no documentation the 30-day requirements were met. Additionally, the record did not reflect the 17-year-old siblings was assessed. The record may not have been all-inclusive of casework activity completed during the investigation, and the investigation remained open at the time this report was written.

PIP Requirement

ACDCYF will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify action(s) ACDCYF has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACDCYF 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?** N/A
- **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?** Unable to determine - insufficient documentation.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The 30-day requirements were not met. It was unable to be determined if additional casework activity was commensurate with case circumstances as there was no documentation in the case record after the date of 4/1/19. The casework activity remained unknown at the time this report was written.

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? No

Explain:
The case remained open at the time this report was written.

Required Actions Related to the Fatality

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

Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-day Fatality Report was not completed in CONNECTIONS as required when a report is made to the SCR alleging the death of a child due to abuse and maltreatment.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	A 30-day Fatality Report will be completed and approved in CONNECTIONS within the first 30 days of an investigation regarding the death of a child.

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	A 30-day Safety Assessment was not completed in CONNECTIONS despite the existence of surviving siblings.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACDCYF will document an assessment of safety and risk of all children in the household within the required timeframe of 30 days.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	When this report was written, there was no record of a CPS history check. Additionally, the record did not reflect fathers were contacted, nor was the 17yo SS assessed.
Legal Reference:	18 NYCRR 428.5
Action:	The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/05/2019 **Time of Death:** 02:25 AM

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

County where fatality incident occurred: Albany
Was 911 or local emergency number called? Yes
Time of Call: 01:50 AM
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? 3 Hours
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	6 Month(s)
Deceased Child's Household	Father	No Role	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	17 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Other Household 1	Other Adult - BF of SS	No Role	Male	37 Year(s)
Other Household 2	Grandparent	Alleged Perpetrator	Female	58 Year(s)

LDSS Response

On 3/5/19, ACDCYF received the fatality report from the SCR. At the time the report was received, the family was active in a Family Services Stage. ACDCYF initiated their investigation by contacting medical providers and conducting a home visit. Attempts were made to contact the source upon receipt of the report to no avail. An unannounced home visit made to the family's home was unsuccessful; however, CW made contact with the maternal grandmother and the four youngest surviving siblings within the first 24-hours of the investigation. The 17-year-old SS was incarcerated at the time the SCR report was made.

A home visit to the grandmother's residence was completed on 3/5/19. She said on 3/4/19, she called the mother around 11:00 PM and noticed the background was inordinately quiet. She asked the mother to check on the child and then heard the mother scream, was told to call 911 and the phone went dead. She contributed this to domestic violence, as there was a history in the family. The grandmother reported she called 911 and ran to the mother's house and saw the EMTs carrying the child down the stairs while performing CPR. She rode in the ambulance with the child; the mother stayed in the home with the four surviving siblings. She reported she saw the child days prior to his death and he appeared happy, healthy, and acted normally.

On 3/5/19, the four youngest siblings were observed. The CW was notified that the siblings were unaware of the child's death. The siblings (ages 6, 9, and 12 years) were interviewed together in the grandmother's home. They believed the child was ill and at the hospital. The 12-year-old sibling said sometimes the child slept on his mother's chest. It was determined there was ample food available to them, and that no adult would be impaired while caring for them. The children gave inconsistent reports of domestic violence between the mother and the father of the child.

On 3/5/19, the mother was interviewed regarding the death. She said the child acted normally, was healthy and laughing the day prior to his death. Around 10:30 PM, she laid him to sleep in his bassinet. She checked on him over the next few hours and observed him sleeping and sucking on his fingers. She was on the phone with her mother when she saw fluids coming from his nose. She told her mother to call 911 and performed CPR on the limp child. She said the child had no known medical conditions and was up-to-date on his immunizations. The father was not home at the time of the fatal incident and had no information to add.

Collateral contacts were made and first responders, including fire fighters, EMS, and LE provided information relating to the death. LE observed a pillow, blanket, bottle and pacifier in the child's sleeping area. The fire fighters stated they were first to arrive on scene, and the mother was walking up the street when they arrived, not performing CPR. It was reported that there was nothing in the child's stomach evidenced by the absence of vomit while CPR was performed. It was

believed the child suffocated and had been deceased for several hours before the mother discovered him, as his extremities were cold.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The death was referred to the Child Fatality Review Team during the course of the investigation.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050721 - Deceased Child, Male, 6 Month(s)	050707 - Grandparent, Female, 58 Year(s)	DOA / Fatality	Pending
050721 - Deceased Child, Male, 6 Month(s)	050699 - Mother, Female, 35 Year(s)	DOA / Fatality	Pending
050721 - Deceased Child, Male, 6 Month(s)	050707 - Grandparent, Female, 58 Year(s)	Inadequate Guardianship	Pending
050721 - Deceased Child, Male, 6 Month(s)	050699 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Pending

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?	☐	☒	☐	☐
School	☐	☒	☐	☐
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?	☒	☐	☐	☐
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: A 30-day Safety Assessment was not completed.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐
Explain as necessary: No children were removed as a result of the 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:
The family was offered grief counseling, Wave Riders and burial assistance. It was unknown if the family utilized the services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was offered services in response to the fatality; however, it remained unknown if the family utilized the resources.

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? Yes

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)
10/24/2018	Deceased Child, Male, 1 Months	Mother, Female, 34 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 1 Months	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report alleged the mother gave birth to the SC, who was born prematurely at 33 weeks. He displayed markers for Fetal Alcohol Syndrome and had difficulty feeding. He had poor coordination when sucking and breathing, and his heart rate and oxygen saturation were monitored. The mother refused to follow through with recommendations and was non-compliant with the child's condition. The mother's refusal to cooperate and inability to retain the medical information provided to her placed the child at risk of death.

Report Determination: Indicated **Date of Determination:** 12/03/2018

Basis for Determination:
The allegations of IG and PD/AM regarding the SC against the SM were substantiated. The investigation revealed the SC had markers of Fetal Alcohol Syndrome and a safety plan was created with the family. The MGM would assist with the care of the SC as the mother was not following through with medical recommendations. Collateral contacts provided information that the mother smelled of alcohol and marijuana.

OCFS Review Results:
The investigation was initiated timely; however, the safety plan was not appropriate. The Safety Assessments were completed inaccurately. The RAP was not all-inclusive of information obtained. Although the legal department was consulted, a Neglect Petition was not filed, and the investigation was closed without resolution. ACDCYF opened a Family Services Stage to monitor the family.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The Safety Assessments and RAP did not note the parent's inability to protect SC or the unwillingness to address areas of concern. Safety Factors should have included the Hx of DV and inability to meet SC's needs. The safety plan was

inappropriate as the record noted the MGM was unreliable. The investigation was closed without a Neglect Petition filed and there was no resolution to the concerns.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/18/2018	Sibling, Female, 8 Years	Sibling, Male, 37 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 8 Years	Sibling, Male, 37 Years	Lacerations / Bruises / Welts	Substantiated	

Report Summary:

An SCR report alleged on 8/17/18, the father of the 6 and 8yo SS grabbed and lifted the 8yo SS by her arm. As a result, she sustained a hand and fingertip bruise on her left arm. The mother and 6yo SS had unknown roles. Additional reports were made to the SCR regarding the SC; however, were investigated in separate investigations.

Report Determination: Indicated | **Date of Determination:** 11/26/2018

Basis for Determination:

The allegations of the report were substantiated against the father of the SS. CW made attempts to contact the father to no avail. The SS was observed with bruising consistent with the allegations. The family was interviewed and credible evidence was revealed that the child sustained bruises as a result of her father picking her up forcefully by her arm.

OCFS Review Results:

The investigation was initiated timely and the source of the report was contacted. Although subsequent SCR reports were made, the record did not include all information regarding their concerns. There was no record there were interviews with two of the SS, or the father. The record did not reflect diligent attempts to contact the fathers, and safe sleep literature was not provided. The 7-day Safety Assessment was completed timely; yet progress notes were untimely. The case was closed without resolution to all concerns presented. Household members were not added to the investigation. The final Safety Assessment and RAP were not accurately completed.

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

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Some progress notes were entered over two months after their event dates.

Legal Reference:

18 NYCRR 428.5

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

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

Summary:

The record did not reflect the 10yo or 17yo SS were interviewed regarding safety and risk, and there was no record the 17yo SS was seen. The documentation did not reflect the fathers of the children were made aware of the SCR report or attempted to be contacted to obtain information regarding the safety and possible risk of their children.

Legal Reference:

432.1 (o)

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Failure to provide safe sleep education/information

Summary:

Although a child was born during the investigation, the record did not reflect safe sleep information and guidelines were provided to the mother.

Legal Reference:

13-OCFS-ADM-02

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

Although some risk factors were identified and explained, some risk factors were not selected. Case information included a new infant was born during the investigation, and the mother was not following medical recommendations for the child, placing him at risk of death; however, the risk factors were not selected. The RAP did not include risk factors regarding the father's aggressive behavior.

Legal Reference:

18 NYCRR 432.2(d)

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The Safety Assessment completed at the time of case closure noted no safety factors; however, the case record noted the mother was not properly caring for the subject child or following medical recommendations. Additionally, a safety plan was created with the family in order to prevent the subject child from being removed from the care and custody of his parents.

Legal Reference:

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

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/19/2018	Sibling, Female, 5 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 2 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	

Report Summary:

An SCR report alleged the parents had an ongoing history of physical abuse in the presence of the children. On 6/19/18,

the parents had an argument that became physical. The father hit the mother in her head, causing her to fall. The incident occurred in the presence of the 1yo SS and 7yo SS. It was unknown if the other children were present. Subsequent SCR reports were made and addressed in concurrent investigations.

Report Determination: Indicated | **Date of Determination:** 11/26/2018

Basis for Determination:
During the investigation, the mother disclosed verbal and physical domestic violence with the father. A SS disclosed being witness to physical domestic violence incidences, and the mother accepted referral information regarding domestic violence. The allegations were indicated and the case was closed.

OCFS Review Results:
The source of the report was contacted, collateral contacts were spoken to, and a home visit was conducted. After identifying a service need, CW provided DV advocate information to the mother. There was no documentation of attempts to contact fathers of the children. Subsequent SCR reports were received during the investigation, which were partly documented. Progress notes were entered untimely. There was no CPS history check noted. The investigation was closed without documentation of a resolution to identified concerns.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The investigation was not all-inclusive of the concerns identified. Although subsequent reports were investigated concurrently, the record was missing information. There was no CPS history check, and there were not attempts to contact the fathers. Notes were entered up to 5 months after their event dates, and the investigation was closed without resolution. The 17yo SS was not assessed.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/01/2018	Sibling, Male, 12 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 8 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 6 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 2 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 12 Years	Mother, Female, 35 Years	Educational Neglect	Unsubstantiated	
	Sibling, Female, 8 Years	Mother, Female, 35 Years	Educational Neglect	Unsubstantiated	

Report Summary:
An SCR report dated 3/1/18 alleged the 12yo SS and 7yo SS had unexcused absences from school and were failing as a result. The mother was aware and did not take effective action to resolve the problem. During the investigation, four additional SCR reports were made regarding the mother's alcohol and marijuana use and concerns of the parents fighting in the presence of the children. The SC was reported to have Fetal Alcohol Syndrome and the SM was noncompliant with medical recommendations, which placed the SC at risk of death.

Report Determination: Unfounded | **Date of Determination:** 11/21/2018

Basis for Determination:
The allegation of EdN regarding the SS was unsubstantiated. IG of three SS were unsubstantiated regarding the SS

against the father. Although it was noted that the 7yo SS was expelled from school as a result of headlice, the investigation was unfounded as the children were transferred to another school and advanced to their next grades. The investigation conclusion did not address the allegations regarding IG of two of the SS.

OCFS Review Results:
The record did not reflect the allegations were addressed with the family until 27 days into the investigation. A CPS history check was not completed. Progress notes were entered non-contemporaneously, and documentation showed the investigation was initiated a week after the report was received. Multiple SCR reports were investigated and revealed concerns that should have been added as allegations but were not and/or cases were not merged to reflect all allegations. The RAP and 7-day Safety Assessment were completed inaccurately, and did not reflect the family's financial hardships, DV or a child under one year old in the RAP family unit.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
ACDCYF addressed some allegations presented by the SCR; however, the case record was not all-inclusive of comprehensive casework. Each CPS investigation must "stand alone" whether or not information was documented in concurrent investigations. Safety Assessments and RAPs must reflect case record information at the time in which they are completed.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/24/2018	Sibling, Female, 7 Years	Mother, Female, 34 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Female, 7 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 11 Years	Mother, Female, 34 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 11 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
Seven SCR reports were made between 1/24/18-10/24/18 that included concerns for the siblings missing excessive amounts of school, the mother abused drugs and alcohol to the point of impairment and engaged in domestic violence while caring for the children. The SC was born during the investigation and the mother was unable to provide appropriate care for him.

Report Determination: Unfounded | **Date of Determination:** 11/21/2018

Basis for Determination:
Despite additional allegations received from the SCR, they were not added to the investigation and the investigation conclusion spoke solely to the initially reported concerns. The allegations of IG and EdN regarding the then 5 and 7-year-old SS were unsubstantiated. The SM treated their head lice and the SS did not suffer academically.

OCFS Review Results:
CW completed a CPS history check and made appropriate collateral contacts. The Safety Assessments dated 11/18/19 did not accurately reflect the case record. The RAP did not include all risk factors documented in the case record. Although there was a legal consultation, and follow up with the family was recommended, the case was closed without further action documented in the case record. The record did not show safe sleep information was provided. The record did not show attempts to contact all fathers. The 16yo SS was not assessed. Despite new allegations reported and investigated, they were not added to the investigation. Progress notes were not entered contemporaneously.

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

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
Although completed, the Safety Assessments throughout the case record did not reflect case circumstances. The case record noted two safety plans made with the family, yet "no safety factors" was selected. The investigation revealed there was DV between the parents in the presence of the children and the SC was medically fragile.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The Risk Assessment Profile was completed inaccurately. The SC was a child under the age of 1 when the RAP was completed.
Legal Reference:
18 NYCRR 432.2(d)
Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Multiple progress notes were not entered contemporaneously with their event dates. Some notes were entered nine months after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
Although listed on the report, the safety of the 17yo SS was not assessed during the investigation. Additionally, there were no documented attempts to contact the fathers of the children regarding the SCR reports, or to assess the safety/risk of the children.
Legal Reference:

432.1 (o)

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Failure to provide safe sleep education/information

Summary:

Although the family had a newborn child, the case record did not reflect safe sleep guidelines or literature were provided to the family.

Legal Reference:

13-OCFS-ADM-02

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/19/2017	Sibling, Female, 5 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 5 Years	Mother, Female, 34 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 34 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:

An SCR report alleged the mother was aware the 7yo SS had a history of having headlice. The SS was sent home from school as a result, and had not returned. The mother did not cooperate with school staff for the planning of the SS' program needs with school, including any medical documentation that the SS received treatment for the headlice. On 11/30/18, an SCR report was made alleging the 5yo SS had untreated headlice.

Report Determination: Unfounded | **Date of Determination:** 11/21/2018

Basis for Determination:

ACDCYF did not find credible evidence to support the allegations. The mother did not follow instruction to treat her children for headlice and the children missed school as a result; however, the headlice was remedied and the children advanced to their next grade levels.

OCFS Review Results:

CW contacted the sources of the reports and completed thorough interviews with the mother. The record did not show all fathers were contacted regarding the SCR reports. The 7-day Safety Assessment was not completed timely, and the RAP was not completed accurately. Progress notes were not entered timely. The sleeping areas of the children were observed and deemed safe.

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

Although the 7-day Safety Assessment was completed accurately, it was not completed until 43 days after the due date.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

PIP Requirement:

ACDCYF will submit a PIP to the Albany Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the ACDCYF has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACDCYF will review the plan and revise as needed to address ongoing concerns.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The Risk Assessment Profile was completed inaccurately. Although risk factors were identified in the RAP, the birth of the subject child, and his 11 month old sibling was not properly documented.

Legal Reference:

18 NYCRR 432.2(d)

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

Although the father of the two youngest children was seen, the record did not show he was spoken to regarding overall safety and risk of the children. There were no documented attempts to contact the fathers of the other children in regard to the SCR reports.

Legal Reference:

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

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Several progress notes were entered approximately 8 months after their event dates.

Legal Reference:

18 NYCRR 428.5

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/27/2017	Sibling, Male, 16 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 16 Years	Mother, Female, 34 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:

An SCR report received on 04/27/17 alleged on the night prior, the 16yo SS attempted to rob a group of unknown individuals. The individuals physically assaulted the SS. As a result, the child sustained lacerations, blurred vision and extensive face and head injuries. The SS required a medical procedure. The mother was aware of the situation and of the

required procedure. She became irate and refused to sign consent for the medical procedure. As a result of the mother's refusal, the child was at risk of severe brain trauma.

Report Determination: Unfounded | **Date of Determination:** 09/26/2017

Basis for Determination:
The allegations were unsubstantiated stating the mother gave authorization for the medical staff to treat the SS for his injuries. Additionally, the mother filed missing persons reports when the SS did not return home. The other children were observed to be safe in the mother's care.

OCFS Review Results:
ACDCYF conducted several home visits and interacted with the children; however, the record did not reflect an attempt to engage any of the children's fathers. ACDCYF contacted the source of the report and completed a CPS history check. The 7-day Safety Assessment was completed timely. The Safety Assessment at the time of case closure was completed inaccurately. The RAP addressed risk factors appropriately. There was no documentation the fathers were provided written notice of the CPS report. Some progress notes were not entered contemporaneously to their event dates.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
Although completed accurately, the 7-day Safety Assessment was not approved until 23 days after the due date.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The record did not show attempts to contact or interview any of the biological fathers regarding the CPS investigation, or obtain information regarding the safety of and possible risk to the children.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
Although a Safety Assessment was completed at the time of case closure, the Safety Assessment did not accurately reflect information in the case record. The Safety Assessment did not reflect the whereabouts of the 16yo SS was unknown at the time of case closure, or that the mother was unable to provide adequate supervision and could not control the SS's behavior.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Failure to provide notice of report

Summary:

Although the mother was provided with a Notice of Existence letter, there was no documentation the fathers of the children were provided written notice regarding the CPS investigation.

Legal Reference:

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

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

There were some progress notes that were entered more than four months after their event dates.

Legal Reference:

18 NYCRR 428.5

Action:

The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

[redacted]

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

11/5/10- 3/7/11 SM UnSub for IG and LS for 22, Sub for PD/AM.

5/12/11 -10/6/11 SM UnSub for IG, LMC and EdN of SS.

11/2/12- 1/16/13 SM Sub for IG and PD/AM of SS.

6/17/13 -9/25/13 SM UnSub for IG, EdN, LS of SS.

8/30/13 -11/19/13 SM UnSub for IG, LS and LMC of SS.

5/2/14 -10/13/14 SM UnSub for C/T/S, IG, LS. PD/AM of SS, Sub against BF of SS regarding SS.

11/8/14- 4/13/15 SM UnSub for C/T/S, IG, L/B/W of SS.

1/8/15- 11/10/16 SM Sub for LMC of SS.

7/13/15- 11/10/15 SM and BF UnSub for IG, C/T/S regarding SS.

12/23/15 -3/17/16- SM Sub for IG of SS, UnSub for IF/C/S, LMC, PD/AM of SS, BF UnSub for IG, I/F/CS, PD/AM for SS.

Known CPS History Outside of NYS

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

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 11/26/2018

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 11/26/2018

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☐	☒	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☐	☒	☐	☐
Did all service providers comply with mandated reporter requirements?	☐	☒	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☐	☒	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The most recent FASP was approved two days after the due date.				

Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☐	☒	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
ACDCYF contracted with Parson's and Healthy Families.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Timeliness of completion of FASP
Summary:	Although completed, the FASPs were not completed by their due dates.
Legal Reference:	18 NYCRR428.3(f)
Action:	ACDCYF will complete timely and accurate FASPs.
Issue:	Adequacy of case recording in FASP
Summary:	Although some safety and risk factors were identified, the SM's alcohol abuse and her unwillingness to obtain medical insurance for the CHN should have been considered. The scaling questions did not always reflect case circumstances.
Legal Reference:	18 NYCRR 428.6(a)
Action:	ACDCYF will accurately record information gathered about family members in receipt of child welfare services, including preventive services, with evaluations and assessments of the family.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Progress notes were entered up to 4 months beyond their event dates.
Legal Reference:	18 NYCRR 428.5
Action:	The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Preventive Services History

The family was involved in a FSS from 1/28/11-9/30/13 after referred by CPS. The SM struggled with MH challenges and experienced DV. CWs made attempts to engage the SM and provide support, as she was overwhelmed with her CHN. The case was closed on 9/30/13 after ACDCYF made numerous attempts to engage the family.

An FSS opened on 9/22/14 when referred by a probation officer of the 17yo SS. The SS was placed on Diversion Services after attempting to steal from a store; he had a Hx of unmanageable behaviors. An Article 3 (JD) petition was filed against him; he was ordered to FC placement. While in the care of ACDCFY, the SS attempted to rob others. As a result, he was physically assaulted, requiring emergency medical procedures. He was arrested, and his Order of Placement was vacated by the judge on 5/2/17, stating "medical reasons" and the SS had criminal charges pending. The case was closed on 5/4/17.

An FSS was opened from 6/26/17- 5/18/18 after referred by CPS. The 17yo SS was arrested for attempting to rob others and was assaulted as a result. The SM and SS were traumatized and the SM desired MH counseling. She was overwhelmed with her CHN and the 17yo SS' behaviors. The family had few supports and ACDCYF made referrals. CW made several attempts to engage the family, but was unsuccessful; due to the family's noncompliance and lack of engagement, ACDCYF closed the FSS.

Foster Care Placement History

There were no children in Foster Care at the time of the fatality.

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