Child Fatality Report

Report Identification Number: SY-22-003

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

Issue Date: Jul 06, 2022

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 28 day(s)
Jurisdiction: Broome
Gender: Male
Date of Death: 01/13/2022
Initial Date OCFS Notified: 01/13/2022

Presenting Information

An SCR report was received which alleged that on 1/12/22, around 11:00PM, the mother and father put the four-week-old subject child down to sleep in an unknown location, and failed to check on the child for approximately 8 hours. At around 8:00AM on 1/13/22, the child was found unresponsive in a onesie, with a blanket, possibly in a portable crib or swing. One of the adults called 911, and the child was pronounced dead by emergency responders. The child was otherwise healthy and there was no explanation for his death.

Executive Summary

This fatality investigation concerns the death of a four-week-old male subject child that occurred on 1/13/22. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother, father, and maternal great grandmother. At the time of the child's death, the family was involved in two concurrent Family Assessment Response (FAR) cases, which were initiated on 7/30/21 and 12/17/21. Those cases were received after concerns arose surrounding substance abuse, deplorable home conditions, and inadequate supervision. The latter case was opened after the subject child was born with a positive toxicology for marijuana. Broome County Department of Social Services (BCDSS) received the fatality report and investigated the child's death. An autopsy was completed and the final report noted the cause of death was "Probably Unsafe Sleep Environment."

At the time of the fatality, the subject child resided with his mother, one-year-old sibling, and maternal great grandmother. The child's biological father was not involved in the child's life, and his whereabouts were unknown throughout the fatality investigation. The investigation revealed that on the night of 1/12/22, around 11:30PM, the mother placed the child to sleep in a portable crib. The mother reported the child was appropriately swaddled and the portable crib did not contain any other items aside from a fitted crib sheet. The mother checked on the child twice during the night and saw nothing out of the ordinary. At 8:00AM on the morning of 1/13/22, the mother awoke to find the child unresponsive in the portable crib. The mother ran with the child down the stairs to the maternal great grandmother and the maternal great grandmother called emergency services. An ambulance transported the child to the local hospital where he was pronounced deceased.

BCDSS spoke with family members and collateral sources. There was no evidence that the subject child was abused or maltreated; however, law enforcement and the medical examiner expressed concerns the mother was not being truthful about co-sleeping with the child. The autopsy showed lividity to one side of the child's face, which was indicative of a prolonged pressure. The mother had been educated surrounding safe sleep practices and denied ever co-sleeping with the child at any time since his birth. There was no criminality found regarding the death of the child. By the conclusion of the investigation, a fair preponderance of evidence was not gathered to support the allegations in the report. Therefore, BCDSS unsubstantiated the allegations and closed the case.

PIP Requirement

This review resulted in a citation related to casework practice. In response, BCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the BCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, BCDSS will review the plan(s) and revise as needed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
BCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving sibling.

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:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

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: 01/13/2022 **Time of Death:** 09:00 AM (Approximate)

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

County where fatality incident occurred: Broome
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? 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
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	28 Day(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	64 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	22 Year(s)

LDSS Response

On 1/13/22, BCDSS met with the family at their residence. SM, MGGM, and the SS were present. SS was observed to be free from marks and bruises and appeared healthy. BCDSS asked SM to recount the events leading up to the fatality. SM explained she put SC to bed in his portable crib around 11:30PM on 1/12/22; he was fine and there were no concerns. SM stated SC was a "good sleeper," and only woke up occasionally for nighttime feedings. SM said she checked on SC twice during the night and "he was fine." The record did not reflect what time this occurred. SM explained that at 8:00AM on 1/13/22, she found him in the portable crib not breathing. SM and MGGM both denied SC had fallen or was shaken and reported they were unaware of anything that would have caused this to happen. BCDSS observed the home and noted no safety concerns. A portable crib was seen, and SM explained she only had a fitted crib sheet and no other objects. SM stated SC was wearing a onesie and a Velcro swaddle. SM reported she also used a "co-sleeper" from time to time, which looked like a bassinet, and would place it on the floor next to SM's bed. SM denied SC was in the co-sleeper the previous night and denied any unsafe sleep practices. SM stated she smoked cigarettes and marijuana, and the last time she used marijuana was a week ago; SM agreed to attend a drug screening. MGGM's account of events corroborated SM's. MGGM stated she was making breakfast that morning and suddenly heard SM "wailing," and running down the stairs. MGGM stated she called 911 and began CPR on SC. MGM arrived at the home during this visit and spoke with BCDSS. MGM

denied any concerns surrounding SM's care of SC, and reported SC was "fine," had no recent fevers or breathing issues.

On 1/14/22, BCDSS received information that SM's drug screen was positive for marijuana only. On this same date, BCDSS received medical records that indicated no medical concerns for SC or SS. It was noted SC was overall a healthy infant. The records also noted safe sleep practices were discussed with SM.

Throughout the investigation, LE and the ME expressed concern that SM was not being truthful about SC's sleeping environment on the date of the fatality. The ME explained one side of SC's face had an indication of lividity, which would have been caused by a prolonged pressure. LE reported they felt SM was co-sleeping with SC, as the swaddle they found in the portable crib was "perfectly placed" and the door to the bedroom was closed when first responders arrived. Considering this information, LE and BCDSS again met with SM and other family members, who all denied SM had ever co-slept with SC.

BCDSS offered the family services in response to the fatality. BCDSS was unable to locate SF, therefore he was not interviewed regarding the fatality. On 4/21/22, BCDSS received the final autopsy report which noted the cause of death as "probably unsafe sleep environment." There were no criminal charges brought against any caregivers regarding the death of SC. A fair preponderance of evidence was not found to support SM's actions or inaction placed SC at imminent risk of harm or his death. Therefore, the investigation was unfounded and the case was closed.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
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: This fatality investigation was conducted by the Broome County MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was submitted for review by the Broome County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060597 - Deceased Child, Male, 28 Days	060600 - Grandparent, Female, 64 Year(s)	DOA / Fatality	Unsubstantiated
060597 - Deceased Child, Male, 28 Days	060600 - Grandparent, Female, 64 Year(s)	Inadequate Guardianship	Unsubstantiated
060597 - Deceased Child, Male, 28 Days	060598 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
060597 - Deceased Child, Male, 28 Days	060598 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
060597 - Deceased Child, Male, 28 Days	060599 - Father, Male, 22 Year(s)	DOA / Fatality	Unsubstantiated

060597 - Deceased Child, Male, 28 Days	060599 - Father, Male, 22 Year(s)	Inadequate Guardianship	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:

BCDSS interviewed family and appropriate collateral sources; however, the father could not be located during the investigation. The sibling was unable to be interviewed due to her age. Progress notes were completed and entered timely.

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?				

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: BCDSS offered the family appropriate services in response to the SC's death.				

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?	☐	☒	☐	☐
Explain as necessary: The surviving sibling did not need to be removed as a result of this fatality report.				

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
BCDSS offered the family appropriate services in response to the child's death. Due to the mother's history of marijuana use, substance abuse services were offered but declined.

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:
BCDSS provided referrals for grief and bereavement counseling to the parents for the sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
BCDSS provided referrals for grief and bereavement counseling to the family following the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☒ Used illicit drugs

Infant was born:

- ☒ Drug exposed
- ☐ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/17/2021	Deceased Child, Male, 1 Days	Mother, Female, 21 Years	Inadequate Guardianship	Far-Closed	No
	Deceased Child, Male, 1 Days	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
This SCR report was received with concerns SM and SC tested positive for marijuana after delivery. SM admitted to marijuana use, and SC had no signs of withdrawal.

OCFS Review Results:
This investigation was tracked as FAR. BCDSS spoke with SM and hospital staff. There were no concerns of a negative impact on SC due to the positive toxicology. SM reported she no longer used marijuana and did not plan to use again. BCDSS reviewed safe sleep practices with SM and observed appropriate provisions. The home was assessed as safe. SM stated BF was denying paternity of SC and was not involved with either CH. Both SC and SS were observed and no concerns were noted. The FLAG was completed. SC died during this investigation and the FAR case was closed, and the SCR reported fatality investigation began.

This investigation met all statutory requirements.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/30/2021	Sibling, Female, 10 Months	Mother, Female, 20 Years	Inadequate Food / Clothing / Shelter	Far-Closed	Yes
	Sibling, Female, 10 Months	Mother, Female, 20 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 10 Months	Mother, Female, 20 Years	Lack of Supervision	Far-Closed	
	Sibling, Female, 10 Months	Father, Male, 21 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 10 Months	Father, Male, 21 Years	Inadequate Guardianship	Far-Closed	

	Sibling, Female, 10 Months	Father, Male, 21 Years	Lack of Supervision	Far-Closed

Report Summary:
This SCR report was received with concerns that on a regular basis, the home was in deplorable conditions with garbage, moldy food, dirty dishes and clothes, and soiled diapers. The report further alleged SS was not bathed or changed regularly, and often appeared dirty with severe diaper rashes. On an unknown date, SM and SF failed to adequately supervise SS, and as a result, SS fell and burned herself on a candle and a fire pit. SM and SF left drug paraphernalia accessible to SS in the past.

OCFS Review Results:
This report was tracked as FAR. BCDSS conducted a home visit and found the home to be tidy with clear pathways but cluttered with boxes of clothes and toys against the walls. SS was observed to be free of marks and bruises, clean, and dressed appropriately. The FLAG was completed, and SM denied all allegations. The FAR case was closed with no noted concerns.

There was no documented casework activity from 7/30/21, the date the report was received, to 12/17/21, the date a subsequent report was received. There were no attempts to meet with BF, and there were no collateral sources contacted to support or contradict the allegations in the report. The FLAG was not completed until 1/18/22.

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

Issue:
FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible
Summary:
The father was named as a subject in the report; however, the record did not reflect any attempts to interview him regarding the allegations.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)
Action:
FAR workers must work in partnership with the families participating in a family assessment response. To the extent feasible, CPS workers should include all family members in discussions, including children who are old enough to express opinions, as well as any other persons who the family would like to include, such as members of the extended family.

Issue:
FAR-Failure to Address Reported or Identified Concerns
Summary:
The record did not reflect the reported concerns surrounding the sibling sustaining burns in the past were addressed with the family.
Legal Reference:
18 NYCRR 432.13 (a)(3)(iii)
Action:
When a report alleging maltreatment of a child is assigned to the FAR track, BCDSS must engage the family in an assessment of: the concerns reported to the SCR, any family-identified needs and concerns that may impact the safety or risk of children, and the family's strengths and resources that could be engaged to address the identified concerns.

Issue:
FAR-Complete Collateral Contacts with Family's Permission
Summary:
The record did not reflect relevant collateral sources were contacted regarding the concerns alleged in the report. This could have included the sibling's pediatrician, who would have seen the sibling regularly and could attest to the parents' caretaking abilities, the condition of the sibling, and any previous injuries the sibling may have sustained.

Legal Reference:
18 NYCRR 432.13 (d)(2)(ii); 18 NYCRR 432.13 (e)(1)
Action:
FAR staff should ask the parents/caretakers for their recommendations regarding collateral sources that could supply information needed to determine the presence of safety factors within the family.

Issue:
FAR-Timely/Adequate Family-Led Assessment Guide
Summary:
The FLAG was not initiated or completed until 1/18/22, nearly five months past the required timeframe.
Legal Reference:
18 NYCRR 432.13 (e)(2)(iii)-(v)
Action:
The family-led assessment guide should be initiated as soon as possible after receipt of the child protective service report, but no more than 30 days following receipt of the report.

Issue:
FAR-Insufficient Number of Casework Contacts
Summary:
There was no documented casework activity from 7/30/21 to 12/17/21.
Legal Reference:
18 NYCRR 432.13 (e)(4); 18 NYCRR 432.13 (e)(3)(v)(d)(2)
Action:
When a FAR investigation is open past 90 days, the FAR worker and supervisor must document the reason for keeping the case open, including specific goals and steps to achieve those goals; and the FAR worker must make contact with the family no less than once every two weeks during the period past 90 days, and must document each contact.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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

BCDSS has reviewed this report. We are working with OCFS around concerns of prior FAR reports to develop a PIP to help staff better understand FAR practice. These previous reports did not impact the findings or outcome of the fatality.

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