Child Fatality Report

Report Identification Number: AL-22-024

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

Issue Date: Mar 01, 2023

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 had an open investigation or a CPS monitored services 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
Jurisdiction: Rensselaer
Date of Death: 09/07/2022
Age: 6 year(s)
Gender: Female
Initial Date OCFS Notified: 09/08/2022

Presenting Information

An SCR report alleged that on 9/7/22, the 6-year-old female subject child arrived home from school and was not feeling well. At an unknown time, the child went into her bedroom to lay down. Between 10:00PM and 10:30PM, the mother went to check on the child and found she had defecated on herself and the bedding. The mother brought the child to the mother's bedroom so the child could lay down and so she could clean up the bed. When the mother returned to check on the child, she found her unresponsive. The mother contacted emergency medical services at 11:38PM and they transported the child to the hospital where she was pronounced deceased. The child was otherwise healthy and the mother did not have an explanation for her death.

Executive Summary

This fatality report concerns the death of a 6-year-old female child that occurred on 9/7/22. The investigation began on 9/8/22, after an SCR report was received with concerns that while in the care of the mother, the subject child became unresponsive at the home. A report was made to the SCR with allegations of Inadequate Guardianship and DOA/Fatality against the mother. The mother and child lived with the aunt and two cousins, ages 4 and 6-years-old. The cousins were assessed to be safe in the care of the aunt. The father lived outside of the home and had regular contact with the child.

On 9/8/22, Rensselaer County Department of Social Services (RCDSS) learned of the death of the subject child and immediately began gathering information related to the incident. It was learned that on 9/6/22, the child went to school and had three episodes of fecal incontinence during the day. The school nurse contacted the mother several times to no avail. The school contacted the child's grandmother, who notified the aunt. The aunt picked the child up from school. The mother cleaned the child up and she was was not feeling sick and appeared to be acting normally. The child played in her room, ate dinner and then watched television in her room before the mother helped the child prepare for bed at 9:00PM. The aunt checked on the child before leaving to work a night shift. The child appeared fine but the aunt noted a smell of feces and notified the mother before leaving. The mother discovered the child had another accident and carried her downstairs to give her a shower. The mother left the child in front of the shower while she went to get clean clothes. Upon her return, the child was laying down and unresponsive. The mother notified the father, called 911 and began cardiopulmonary resuscitation. First responders arrived and continued life saving measures at the home before transporting the child to the hospital where she was pronounced deceased.

An autopsy was completed and the final cause and manner of death were pending the results of additional tests. It was reported that the child had no signs of trauma, no fractures, no signs of neuro or cardiac issues, and no indications of maltreatment. The child had a large amount of bound up fecal matter, and her bowels were impacted and irritated. Law enforcement investigated the fatality and their criminal investigation remained open pending the results of the final autopsy. RCDSS contacted first responders, doctors, relatives and school personnel. There was no concern noted for the condition of the child's home, the medical care of the child or substance misuse. While a historical CPS investigation indicated concern regarding the mother's attention to the child's incontinence, contact with the family and collaterals revealed the mother spoke to the child's doctor regarding the condition, and the father and mother were working to address the condition per the recommendation of the child's pediatrician. According to relatives and school personnel, the child had not expressed or displayed any signs of pain or illness. It was noted that the child's incidents of fecal incontinence had improved since the prior indicated CPS investigation in March 2022.

RCDSS offered the family grief counseling services and provided an application for assistance with the funeral

arrangements. RCDSS reviewed medical records, which showed the child was up to date medically and the mother had expressed appropriate concern for the child's incontinence. The family and collaterals did not observe the child to be in any pain leading up to her death. At the time of case closure, the medical examiner was waiting for the results of several tests and there was no time frame as to when the final report would be ready. RCDSS concluded that there were no signs of maltreatment or abuse regarding the death of the child and the investigation was unfounded and closed on 1/9/23.

PIP Requirement

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:

The safety of the cousins was regularly assessed throughout the investigation. RCDSS made an appropriate determination given the information gathered.

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:

All casework activity was commensurate with 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: 09/07/2022 **Time of Death:** 01:30 AM (Approximate)

Time of fatal incident, if different than time of death: 11:00 PM

County where fatality incident occurred: Rensselaer
Was 911 or local emergency number called? Yes
Time of Call: 11:38 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☒ Other: Sitting on the bathroom floor

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	29 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	6 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	6 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	4 Year(s)
Other Household 1	Father	No Role	Male	29 Year(s)

LDSS Response

Upon receipt of the SCR report on 9/8/22, RCDSS initiated their investigation and coordinated efforts with LE, notified the DA and CAC, interviewed the parents and collaterals, completed home visits and offered services regarding the fatality.

RCDSS interviewed the MA, who reported on 9/6/22, she was notified by the MGM that the school was trying to contact the SM regarding the SC having three incidents of fecal incontinence at school. The MA explained that the SM did not have any minutes on her phone. The MA picked up the SC and she acted normally on the drive home. The SC did not

report being in any pain and did not display any signs of pain. The MA left for the night around 10:00PM and said goodbye to the SC before leaving. The SC was sitting up in bed watching television and said goodbye to the MA. The MA said she appeared fine but smelled of feces. The MA notified the SM of this. While at work, the MA was notified by a friend that the SC became unresponsive at the home. The MA reported the SC was active, ate a normal diet, and that her fecal incontinence had improved. The MA had no concerns for the SC in the care of either parent.

The SM was interviewed by RCDSS regarding the events leading up to the SC's death. On 9/6/22, the SM put the SC on the bus and then was home the remainder of the day. At 3:00PM, the MA told the SM the school was trying to get in touch with her. The MA picked up the SC while the SM stayed home to get the cousin off the bus. When the SC got home, the SM gave her a shower and checked if she felt warm, which she did not and did not report feeling sick. The SC played in her room until 5:30PM when she came downstairs for dinner and then returned to her room. The SM checked on the SC at 7:00PM and she had no further accidents. The SM helped the SC get ready for bed around 9:00PM. The SM believed the accidents at school were attributed to first day of school nerves. At 10:15PM, the SM was notified by the MA about the SC's room smelling like feces. The SC had defecated on herself and the bed, so the SM picked her up and carried her downstairs. The SM brought the SC into the bathroom and then placed the SC in front of the shower while she went to retrieve clean clothes. The SC kept telling the SM she was tired. When the SM returned from getting clothing, the SC was laying down by the shower and was unresponsive. The SC’s mouth was moving, and her eyes were looking in different directions. The SM called the BF around 11:00PM and then called 911. The SM performed CPR at the direction of 911 dispatch until first responders arrived and transported the SC to the hospital.

RCDSS interviewed the BF who reported that he last saw the SC the weekend before her death. The SC was acting normally and was not in any discomfort nor complained of any pain. The BF stated he would have brought the SC to the hospital if she was in pain and believed the SM would have done the same. The BF confirmed the SC had a history of becoming constipated and holding in her bowel movements. They were giving the SC Miralax to help, which she had not needed since the beginning of the summer. The BF reported the SC had only one incident of fecal incontinence in the last month and was not wearing pull-ups since the beginning of summer. On 9/6/22, the BF received a text message at 11:25PM from the SM begging him to help her. The BF called the SM at 11:36PM and the SM told him the SC was not breathing and she was calling 911. The BF went immediately to the SM's home, where first responders were administering CPR to the SC.

RCDSS completed visits to the SM and MA's home and assessed the cousins' safety. The home was determined to be safe. The cousins were interviewed and reported no safety concerns.

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? Yes
Comments: RCDSS indicated that the fatality would be referred to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation

			Outcome
062501 - Deceased Child, Female, 6 Yrs	062532 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
062501 - Deceased Child, Female, 6 Yrs	062532 - Mother, Female, 27 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?	☒	☐	☐	☐

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	☒	☐	☐	☐

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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 aunt was provided information on community-based grief counseling services on behalf of the cousins.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother, father and aunt were offered community-based grief counseling and it was unknown if they enrolled in the service. An application for grief counseling services was provided to the parents.

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

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)
03/18/2022	Deceased Child, Female, 5 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 5 Years	Father, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged that on a daily basis, the then 5-year-old subject child had fecal incontinence. The mother and father were instructed to not send the child to school wearing a pull-up diaper, as she was less likely to use the bathroom when she had one on. The parents continued to send the child to school wearing a pull-up diaper. At times, the child arrived to school wearing a soiled pull-up diaper full of dried feces. The feces placed the child at risk of an infection. The child struggled with her social and emotional development. The parents did not respond to outreach or seek services for the child.

Report Determination: Indicated	**Date of Determination:** 04/29/2022

Basis for Determination:
RCDSS found there was a fair preponderance of evidence to substantiate IG against the SM. Following the SCR report, the SM continued to send the SC to school in pull-ups, sometimes already soiled with urine and feces, presenting a health risk for the child. The SM did not make efforts to correct the SC's fecal incontinence. IG was unsubstantiated against the BF. The BF was not aware of the SC's fecal incontinence and the SC was not having the same problems when she visited his home. The BF began caring for the SC during the week and an improvement was noted by the school.

OCFS Review Results:
RCDSS interviewed the child at school on 3/18/22. Attempted contact with the mother, father and aunt who helped care for the child was not documented until 4/6/22. The child visited with the father regularly and began living with him during the investigation. Though the father was a subject and regularly cared for the child, there were no efforts documented to interview him face to face or assess his home for safety, other than an attempted phone call to the father on 4/14/22. There were concerns noted for the child's development; however, the record did not reflect an assessment was discussed with the family. The condition of the mother's home was not documented.

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

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

Summary:
The mother's interview was allegation focused and did not include questions regarding overall safety and risk factors. The record did not reflect attempts to assess the father's home nor was the condition of the mother's home documented.

Legal Reference:
18 NYCRR 432.1 (o)

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

Issue:
Review of CPS History

Summary:
The record did not reflect a CPS History check was completed.

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

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

PIP Requirement:
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. RCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:

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

Summary:

Other than an attempted phone call on 4/14/22, the record did not reflect any efforts to interview the father face to face.

Legal Reference:

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

Action:

The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Issue:

Failure to Offer Appropriate Services

Summary:

As noted in the case record, the school reported the child should have been evaluated for developmental delays regarding her social and emotional development, which had not been completed by the family as recommended. The record did not reflect this was discussed with the parents or services were offered.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

RCDSS shall, based on the investigation and evaluation conducted pursuant to this title, offer to the family of any child believed to be suffering from abuse or maltreatment such services for its acceptance or refusal, as appear appropriate for either the child or the family or both.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/20/2020	Other Child - Cousin , Male, 4 Years	Aunt/Uncle, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	No
	Other Child - Cousin , Male, 2 Years	Aunt/Uncle, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

An SCR report alleged that the aunt was physically abusive and used profanity towards the cousins. A year ago, the aunt hit the then 2-year-old cousin using excessive force and caused the cousin to fall to the ground. It was unknown if the child sustained any injury. The aunt also hit the then 4-year-old excessively. Sometimes family members intervened and stopped the aunt from hitting the cousins.

Report Determination: Unfounded | **Date of Determination:** 09/07/2020

Basis for Determination:

RCDSS unsubstantiated the allegation of IG. All adults in the home were interviewed and denied all allegations of the report. The cousins appeared well bonded, attached, and comfortable with the aunt. The aunt denied swearing at the children. A minor aunt residing in the home reported the adults did sometimes curse at the cousins, and sometimes this was in a joking manner. A collateral contact reported having no concerns for the family. The investigation revealed the cousins had not been seen by a pediatrician recently. The aunt was instructed to make an appointment and did so.

OCFS Review Results:

RCDSS conducted a thorough investigation and completed all required casework activity. RCDSS spoke to pertinent collaterals and followed up with contacts as needed to discuss the safety of the cousins. Safety Assessments and the RAP were completed with accurate information. RCDSS made diligent efforts to locate and contact the father of the cousins. The determination was made in congruence with the evidence gathered and the investigation was closed in a timely manner.

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

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.

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