Child Fatality Report

Report Identification Number: AL-22-025

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

Issue Date: Feb 13, 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
Age: 4 year(s)
Jurisdiction: Albany
Gender: Male
Date of Death: 09/06/2022
Initial Date OCFS Notified: 09/08/2022

Presenting Information

On 9/7/22, Albany County Department of Children, Youth and Families learned of the death of the 4-year-old subject child that occurred on 9/6/22. At the time of the child's death, the family had 2 open CPS investigations, one of which contained information regarding the fatal incident. Albany County Department of Children, Youth and Families notified the Albany Regional Office via the OCFS 7065 Agency Reporting Form.

Executive Summary

On 9/7/22, Albany County Department of Children, Youth and Families (ACDCYF) learned of the death of the 4-year-old subject child that occurred on 9/6/22. At the time of the child's death, the family had an open investigation regarding the 9-month-old sibling's brain bleed. Additionally, there was another CPS investigation open at the time of death regarding concerns for the mother's mental health, alleged drug misuse and the father perpetrating domestic violence against the mother. ACDCFY had been in contact with the family and hospital staff since being notified of the accident that took place in another state on 8/30/22. The siblings (aged 9 months, 3 and 6 years) were assessed to be safe throughout the investigation.

Through contact with the parents, extended family members and medical providers, ACDCYF became aware of the child's poor prognosis as a result of the family's minivan being rear-ended by a semi-truck while the minivan was stopped at a red traffic light. The child sustained multiple fractures about his body, an anoxic brain injury, and acute respiratory failure. At the time of the accident, the mother and children were traveling from New York to another state.

It remained unknown if an autopsy was performed; however, the record reflected hospital staff reported the preliminary cause of death was "anoxic brain injury as a result of the car accident." Despite efforts by ACDCFY, they were unable to gather written documentation listing the official cause and manner of death. Law enforcement investigated the accident; however, the accident report was pending at the time of this writing. Law enforcement noted the child was properly restrained and there was no evidence the mother was under the influence of drugs or alcohol at the time of the accident.

The mother, father, first responders, hospital staff and extended family members were interviewed. The father was not present at the time of the fatal incident and did not have additional information. Extended family members reported concerns for the ongoing domestic violence between the parents.

The mother and siblings relocated out of state prior to case closure. The father moved to another state. The family was offered services including bereavement services and funeral assistance. The family initially accepted the referral for bereavement services. The family did not require funeral assistance. Although the family accepted the bereavement services, due to relocating, it remained unknown if they engaged in the services in their new respective states.

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.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
ACDCYF gathered information surrounding the circumstances of the death, made efforts to offer appropriate services and closed the CPS investigations that were open at the time of the fatality.

Was the decision to close the case appropriate? Yes

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

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

Explain:
Casework activity was commensurate for investigating a death that was not SCR reported.

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: 09/06/2022 **Time of Death:** 03:57 PM

Date of fatal incident, if different than date of death: 08/30/2022

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

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 and/or ingested alcohol or drugs? N/A

Child's activity at time of incident:

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

☐ Other

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	4 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Month(s)
Other Household 1	Father	No Role	Male	41 Year(s)

LDSS Response

At the time ACDCYF learned of the family's involvement in a motor vehicle accident, and the subsequent injuries to the subject child and siblings, they coordinated with an out of state child protective agency and contacted the family. After learning about the child's death, ACDCYF notified OCFS via the required 7065 Agency Reporting Form. Throughout ACDCYF's involvement with the family, the parents were in a custody dispute, involving 3 states and the siblings were assessed to be safe in the care of each parent separately.

Prior to being made aware of the death, ACDCYF had gathered information regarding the fatal incident from the out of state child protective agency, hospital staff, the family and law enforcement.

Hospital staff noted that the child was transported to the hospital via helicopter on 8/30/22. The child arrived at the hospital in cardiac arrest with "obvious deformity to the left lower extremity. The child was sedated and "placed on mechanical ventilation." He had trauma to his face and neck, had fractures throughout his body and skull, and scalp and pelvic hematomas. The child was pronounced deceased on 9/6/22 at 3:57 PM.

Law enforcement records documented that the fire department used the Jaws of Life and hydraulic tools to remove the van's sliding door. The child was pinned between the second and third row seats of the van. The records included witness statements noting the driver of the semi-truck was speeding when he hit the van. Immediately after impact, the mother was seen sticking her head and arms out of the vehicle as she screamed for help. At the time first responders arrived, the driver of the semi-truck was crying and stated that his brakes were not working. Law enforcement records also noted that the driver said he was on the phone when he looked down for a moment to set it down, and when he looked up, the traffic light was red. He was unable to use his brakes as a water bottle had fallen and was blocking the brake pedal. Additionally, the law enforcement records included the mother's statement. The mother provided information that she was traveling to another state with her children, who were properly restrained in their seats. She stopped at the traffic light and was rear-ended. The van spun around and went into a ditch. The mother was able to remove the female siblings but was unable to remove the males as their legs were pinned within the van. Law enforcement noted there was no evidence that the mother was at fault for the accident.

The out of state child protection agency interviewed the 6-year-old sibling; however, the record did not reflect he was

asked about the accident.

The mother was offered preventive services through ACDCYF, which she initially accepted as she and the father had ongoing domestic violence incidents and she was seeking assistance in obtaining housing; however, the mother and siblings moved to another state and the mother no longer wanted intervention from ACDCYF. The cases that were opened at the time of death were appropriately determined and closed.

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 referred to an OCFS approved Child Fatality Review Team? Yes

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
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	☒	☐	☐	☐

Explain:
The family accepted grief counseling referrals; however, the mother and siblings relocated to another state. The father moved to a separate state, and it remained unknown if the family members received services in response to the 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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
The siblings did not need to be removed as a result of 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	Offered,	Offered,	Not	Needed	N/A	CDR

	After Death	but Refused	Unknown if Used	Offered	but Unavailable		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:
ACDCYF offered the family services in response to the death; however, it remained unknown if the family participated in services as they relocated.

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? Unable to Determine
Explain:
The siblings were offered grief counseling in response to the death; however, the mother and siblings relocated out of state, and it was unknown if the children were provided with the services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The parents were offered bereavement services. It remained unknown if the parents received services in response to the death as they both relocated to different states.

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? Yes

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)
08/31/2022	Deceased Child, Male, 4 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Months	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 4 Years	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Months	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Months	Mother, Female, 30 Years	Internal Injuries	Unsubstantiated	
	Sibling, Female, 9 Months	Father, Male, 41 Years	Internal Injuries	Unsubstantiated	

Report Summary:
An SCR report alleged on 8/31/22, the 9-month-old sibling presented with a brain bleed that she sustained in the past. The mother and father were unable to provide an explanation for the internal injury; therefore, they were named as subjects. The mother suffered from untreated depression that negatively impacted her ability to provide care for the children, ages 9 months, 3, 4, and 6 years. The mother failed to seek mental health treatment, which was court-ordered. The mother stayed in bed for days at a time and was paranoid. The mother self-medicated with drugs, but it was unknown if she was impaired around the children.

Report Determination: Unfounded **Date of Determination:** 10/21/2022

Basis for Determination:
The Investigation Conclusion Narrative stated on 8/30/22, the mother and the children were in a serious car accident. The family was restrained in the car when they were rear-ended by a semi-truck. The mother denied any substance misuse. A doctor did not believe the sibling's brain bleed was indicative of abuse. Collateral contacts did not have concern for the care of the children.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check was documented timely. The 7-day Safety Assessment was completed timely. Written notice of the SCR report was provided timely. Home visits were made and interviews with the family and collateral contacts were appropriate. The child passed away during the

investigation and ACDCYF gathered relevant information and offered services to the family.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/02/2022	Deceased Child, Male, 3 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 6 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 2 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 2 Months	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 2 Years	Father, Male, 41 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 3 Years	Father, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 2 Years	Father, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 2 Months	Father, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged on 2/1/22, the BF was violent toward the BM in the presence of the CHN. He scratched the BM and hit the now 3-year-old sibling on the head, causing her to bleed. Three subsequent reports were received on 3/14/22 and 3/15/22 alleging the BM misused drugs to the point she slurred and was erratic while caring for the CHN. She screamed at the CHN and hit them with excessive force. A report alleged the BM had untreated mental health disorders. The BM was out of touch with reality, talked about aliens and said that people were not from Earth. The BM said she would kill the BF. The eldest SS cried as a result.

Report Determination: Indicated | **Date of Determination:** 10/07/2022

Basis for Determination:
The father was substantiated for IG regarding the children. The record reflected the father was the perpetrator of verbal and physical domestic violence against the mother in the presence of the children. Collateral contacts confirmed the DV between the parents. The record reflected the eldest sibling was withdrawn when his father was active in his life, and he would have toileting accidents. There was no evidence to support marks or bruises on the youngest sibling or that the mother had mental health disorders which impacted her care of the children or that she misused drugs.

OCFS Review Results:
The investigation was initiated timely, and the sources were contacted. A CPS history check was completed untimely. The 7-day Safety Assessment was completed timely. The RAP was completed with accuracy. There was a predetermination of safety and risk.

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

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

Summary:

There was a predetermination of safety and risk as there was no documented casework contact from 3/31/22- 8/31/22.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

ACDCYF must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

Issue:

Review of CPS History

Summary:

A CPS history check was completed untimely on 8/31/22.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/18/2020	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 4 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:

An SCR report alleged the mother was diagnosed with paranoid schizophrenia and a personality disorder. The mother was not in treatment. As a result, the mother became out of control and yelled and hit the children. On at least 1 occasion, the mother caused the child to sustain bruises. It was unknown if the children had injuries at the time the report was made.

Report Determination: Unfounded | **Date of Determination:** 05/12/2021

Basis for Determination:

The Investigation Conclusion Narrative noted that there was no credible evidence to support the allegations and that the mother denied having mental health concerns.

OCFS Review Results:

The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed untimely. Written notice was provided timely. Home visits were made, and the family and collaterals were contacted.

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day Safety Assessment was completed untimely on 11/30/20.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACDCYF will document and approve all Safety Assessments within the required timeframes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/03/2020	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 4 Years	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 1 Years	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 2 Years	Father, Male, 40 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Years	Father, Male, 40 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 1 Years	Father, Male, 40 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 4 Years	Mother, Female, 28 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 28 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 4 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Report Summary:
An SCR report alleged the BM was not being treated for her MH disorders. She was irate and verbally aggressive. She smoked marijuana and was irritable while caring for the CHN. The BM stayed in bed, leaving the SC and the then 1-year-old sibling in soiled diapers. The BM left the CHN unsupervised. The SC fell and knocked his teeth out, and had other injuries; therefore, required additional supervision. As a result of being unsupervised, the SC injured his head, under his eye and his head was swollen. The home was a safety hazard with clothing, toys, and other items on the floor. The BM failed to address the issue. On 9/2/20, the BM threatened the BF in the presence of the CHN.

Report Determination: Indicated | **Date of Determination:** 05/13/2021

Basis for Determination:
The Investigation Conclusion Narrative noted the BM screamed and hit the BF while he was driving, and the SC witnessed it. The home appeared to “meet minimal degree of care standards” and the CHN appeared clean and healthy. Both parents had a history of being the aggressor in physical disputes. The parents gave conflicting information regarding

the alleged violence in the car; therefore, the allegation of Inadequate Guardianship was substantiated.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed timely. Safe sleep recommendations were provided. Written notice was provided timely. A CPS history check was completed timely. Notice of Existence was provided timely. There was a period when no casework activity was documented. Preventive services were offered to the family; however, they were declined. ACDCYF appropriately added IG regarding the BF.

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

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

Summary:
The record did not reflect there was casework activity from 12/10/20- 5/4/21; therefore, the safety of the children was not assessed continuously throughout the investigation.

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

Action:
ACDCYF must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/10/2020	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 28 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 28 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
An SCR report alleged the mother left the then 3 and 1-year-old siblings, and the child alone for extended periods. The children were too young to be left unsupervised and the children were scared. While unsupervised, the child sustained a scar on his face and had a bruise on his head.

Report Determination: Unfounded | **Date of Determination:** 05/21/2021

Basis for Determination:
The allegations were unsubstantiated as ACDCYF did not reveal credible evidence during their investigation. The mother denied the allegations and that she was always working from home with the children present. The sibling sustained bruises when he fell at the airport and when hit his head on a bunkbed.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. Written notice was provided timely. The children were not assessed in a reasonable timeframe and despite supervisory directive, there was no documented legal consultation regarding obtaining an access order in attempt to assess the children. A CPS history check was documented untimely. The 7-day Safety Assessment was completed timely. There was no noted casework activity for nearly 5 months.

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

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

Summary:
Despite attempts to assess the safety of the CHN from 7/10/20- 7/17/20, the attempts were unsuccessful. There were no documented casework attempts from 7/17/20- 8/20/20. The CHN were not assessed until 8/31/20. There was no legal consultation to obtain an access order, despite supervisory directive to do so. The record did not reflect casework activity took place from 12/9/20-5/4/21.

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

Action:
ACDCYF must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

Issue:
Review of CPS History

Summary:
A CPS history check was completed untimely on 9/3/20.

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/15/2020	Deceased Child, Male, 2 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 3 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Months	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the mother physically abused the father in the presence of the children. It was unknown if the children sustained injuries as a result. The mother displayed aggressive behaviors by threatening to kill the father in the presence of the children. As a result, the children were fearful.

Report Determination: Unfounded | **Date of Determination:** 06/05/2020

Basis for Determination:

The Investigation Conclusion Narrative reflected the parents reported there were no recent incidents of domestic violence or threats. The parents acknowledged they planned to divorce and were in a custody battle. The investigation did not reveal credible evidence and the allegations were unsubstantiated.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. Preventive services were offered to the family. A CPS history check was documented timely. Written notice was provided timely. The record did not reflect relevant collateral contacts were made. The 7-day Safety Assessment was completed timely.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
Although the source of the report was contacted and medical records for the CHN were obtained, the record did not reflect relevant collateral contacts were made to individuals who could provide information regarding family functioning, safety, and risk. Relevant collateral contacts could have included individuals who may have had knowledge of possible DV or the BM's alleged aggressive behaviors.

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

Action:
ACDCYF will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/21/2020	Sibling, Female, 7 Months	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 3 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the BF had a history of violent behavior toward the BM and in the presence of the CHN. On 2/21/20, the BF was angry and threw items in the presence of the CHN. He threw things while he screamed at the BM. The BM went outside to retrieve items from the car. She was sitting in the vehicle when the BF followed her outside and grabbed the BM's arm. He dug his fingernails into her skin and started driving away with both doors open. The CHN were inside by themselves. About 1 year prior, the BF pinned the BM down and poured water on her. During the incident, the BF accidentally kicked the SC and knocked him into a dresser. It was unknown if the SC was injured.

Report Determination: Unfounded | **Date of Determination:** 06/05/2020

Basis for Determination:
The Investigation Conclusion Narrative stated the father denied the allegations and stated that the parents argued, and he attempted to leave. The parents planned to move out of state, and the mother changed her mind. The father denied a physical altercation. Although the children were present during the incidents, ACDCYF deemed they were not in harm's way, and therefore, there was no impact on them. The allegations were unsubstantiated.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. Safe sleeping recommendations were provided. Home visits were made, and the parents were interviewed. The case was closed without a current assessment of the children. A history check was completed untimely. The 7-day Safety Assessment was completed untimely. Written notice was provided untimely.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
Although the children were seen during the investigation, the record reflected the children were last seen on 4/17/20. ACDCYF documented they planned to assess the children; however, they did not document a follow up.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
ACDCYF will prioritize making an adequate assessment of safety and risk to all children in the household and continue an on-going assessment of safety and risk throughout the length of the investigation.

Issue:
Review of CPS History
Summary:
A CPS history check was completed untimely on 4/16/20.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, ACDCYF must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, ACDCYF will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day Safety Assessment was completed untimely on 3/6/20.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACDCYF will document and approve all Safety Assessments within the required timeframes.

Issue:
Failure to provide notice of report
Summary:
The record reflected written notice of the SCR report was provided untimely on 4/20/20.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACDCYF will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/22/2019	Deceased Child, Male, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 3 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Female, 5 Months	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 1 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 5 Months	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report alleged on 12/22/19, the BM spit on the BF and struck him with her fist and hand in the presence of the CHN. The CHN did not sustain injuries. On 12/21/19, the BM was angry and threw a glass. In the week prior, the BF drove with the BM and CHN in the car. The BM struck the BF while the vehicle was moving. In 2016, the BM hit the BF while the eldest SS was present. The BM was diagnosed with anxiety and a personality disorder but was not compliant with attending therapy or taking medication. The BM was suicidal and made homicidal statements toward the CHN.

Report Determination: Unfounded | **Date of Determination:** 06/05/2020

Basis for Determination:
The investigation did not reveal credible evidence to substantiate the allegations. The parents denied the allegations, had ongoing custody battles, and made allegations against one another. The parents each filed for custody but later reconciled. The investigation did not reveal a negative impact on the children.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. Notice of Existence was provided timely. The parents were interviewed, and home visits were made. The 7-day Safety Assessment was completed timely. The Risk Assessment Profile was completed accurately.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/17/2019	Deceased Child, Male, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 3 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 1 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged on 10/16/19, the father pulled the mother out of the car while the car was not in park. The then 3-year-old sibling was in the back seat. The father dragged the mother around a parking lot. The mother sustained scratches to her hand and had a swollen eye.

Report Determination: Unfounded | **Date of Determination:** 06/01/2020

Basis for Determination:
The investigation revealed that although there was physical violence between the parents, ACDCYF was unable to reveal a negative impact on the children. The Investigation Conclusion Narrative stated that the children did not cry and were not scared during the incident. The children were too young to be interviewed.

OCFS Review Results:
The case was initiated timely, and the source was contacted. ACDCYF consulted their legal department. A CPS history

check was completed untimely. Written notice was provided untimely. The parents and collateral contacts were interviewed. The case was inappropriately unfounded.

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

Issue:
Failure to provide notice of report
Summary:
Notice of Existence letters were provided untimely on 10/28/19.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACDCYF will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:
Review of CPS History
Summary:
A CPS history check was completed untimely on 10/28/19.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, ACDCYF must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, ACDCYF will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Appropriateness of allegation determination
Summary:
Although the record reflected the BF dragged the BM around the parking lot and there was physical violence between them, the allegations were unsubstantiated. One of the CHN was in the car, and the others were left unsupervised in the home. The basis for determination reflected the CHN did not cry and were not scared; however, this could not be determined as they were too young to be interviewed.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACDCYF will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Albany Regional Office if further guidance is needed.

[redacted]

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

4/4/13- 5/14/13 The BF was UnSub for IG of his now adult child. The BF was Sub for IG, L/B/W of another now adult child.

7/20/16- 8/29/16 The BF was Sub for IG of the 6yo SS. The BM was UnSub for IG, PD/AM of the 6yo SS, the SC and the BF's now adult child.

1/17/17- 3/8/18 The BM UnSub for IG and PD/AM of the 6yo SS.

8/3/17- 3/8/18 The BM UnSub for IG, PD/AM and LS of the 6yo SS. The BF was UnSub for IG of the 6yo SS.

10/11/17- 3/8/18 The BM was UnSub for IG of the 6yo SS.

2/23/18- 3/8/18 The BF UnSub for IG of the SC and the 6yo SS.

6/1/18- 7/9/18 The BM and BF were UnSub for IG, LS, PD/AM of the SC and 6yo SS.

7/9/18- 8/27/18 The BM and BF were Sub for IG of the 6yo SS, the SC and another child.

2/28/19- 6/1/20 The BM UnSub for IG, IF/C/S and PD/AM of the SC and the 6yo SS.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

Preventive Services History

10/21/21- 4/4/22 A Preventive Service Case was opened as the mother was pregnant and had 3 young children in her care. The mother was in a domestic violence relationship with the father; however, at the time of the case, they were separated. The mother was concerned as to what would happen to the children when she was in the hospital for the birth of the youngest sibling. The mother did not have a support system and was seeking assistance in obtaining childcare options. The mother planned to move out of state to be with family and needed help obtaining provisions for the youngest sibling. ACDCYF provided the mother with childcare referrals and made referrals for the mother to obtain provisions for the sibling. ACDCYF provided the mother with provisions for the sibling and provided ongoing casework monitoring; however, the case was closed at the request of the mother.

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

ACDCYF has no comments in regard to the fatality. We continue to work diligently on our overdue cases to ensure no gaps in contact and services. Although our history check and providing Notice of Existence were untimely, they were documented as done.

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