Child Fatality Report

Report Identification Number: AL-22-026

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
Age: 1 year(s)
Jurisdiction: Fulton
Gender: Male
Date of Death: 09/22/2022
Initial Date OCFS Notified: 09/23/2022

Presenting Information

An SCR report alleged on 9/22/22, at 12:30PM, the aunt (PA) strapped the child (SC) into his car seat for a nap and tightened the straps. The PA checked on the SC around 1:45PM, and found him unresponsive. The PA started CPR and called 911. When EMS responded to the home, the SC's lips, toes, and fingers were blue in color and there was blood coming from his mouth. The SC had ligature marks around his neck from the straps of the car seat. The SC was brought to the hospital and pronounced deceased. The role of the mother, father, and 3 other children were unknown. A duplicate report was made on 11/27/22, that alleged the father poisoned the SC in some unknown manner the same day of the fatal incident.

Executive Summary

On 9/23/22, Fulton County Department of Social Services (FCDSS) received an SCR report regarding the death of the 1-year-old subject child that occurred on 9/22/22. At the time of the child's death, he resided with his father. The mother did not have custody of the child and did not have consistent visitation with the child. On the date of the fatal incident, the paternal aunt was caring for the child. The aunt had three children, ages 12, 6, and 3-years-old. FCDSS assessed the safety of the aunts' children and determined they were safe in the care of the aunt.

FCDSS collaborated investigative efforts with law enforcement upon receipt of the SCR report and learned the child was dropped off to the aunt around 5:15AM, prior to the father going to work. The aunt regularly watched the child during the week while the father worked. The aunt strapped the child into the car seat to take a nap around 12:30PM, covered the child with a blanket, and placed the child in another room of the home. Around 1:45PM, the aunt went to wake up the child and she noticed the child was lower than normal in the car seat, there was drool coming out of the child's mouth, and he was unresponsive. The aunt called 911 and she and a neighbor performed CPR until EMS arrived. EMS transported the child to the hospital where he was pronounced deceased. The father reported it was normal for the child to sleep in his car seat and the child remained buckled in the car seat until he woke up.

FCDSS contacted the medical examiner's office, and an autopsy was performed; however, the final report was pending at the time this report was written. The medical examiner stated the child was not properly secured in the car seat as the straps were too tight and as a result, the child was strangled by them. The marks on the child matched the car seat straps. Law enforcement found no criminality regarding the child's death and the criminal investigation remained open pending the final autopsy report.

FCDSS unsubstantiated the allegations of DOA/Fatality and Lacerations, Bruises and Welts. FCDSS determined there was not a fair preponderance of evidence to support the aunt was neglectful or abusive; however, the case record reflected the aunt placed the child in an unsafe sleep environment with the straps too tight and the child died as a result. The record did not reflect FCDSS addressed a duplicate report that was received during the open investigation that contained new allegations against the father. FCDSS missed an opportunity to interview EMS and hospital staff regarding the fatal incident.

FCDSS offered the father grief counseling services and burial assistance; however, he declined. The mother was offered grief counseling and she declined. The aunt accepted grief counseling services; however, it was unknown if she engaged with the services.

PIP Requirement
FCDSS will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify action(s) FCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, FCDSS 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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:
The duplicate report received on 11/27/22, contained new allegations of IG and P/Nx against the father. The record did not reflect that these allegations were addressed. FCDSS did not make an appropriate determination for some allegations based on the evidence obtained throughout the investigation.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
Casework activity was not commensurate with the case circumstances, the duplicate report was not addressed and the allegations were not determined in accordance with the facts obtained throughout the investigation.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	The record did not reflect the duplicate report made to the SCR on 11/27/22 was addressed. The duplicate report contained new allegations and alleged the father poisoned the SC with an unknown

	substance on the day of the fatal incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	FCDSS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	There was no documentation in the record that the source of the duplicate report dated 11/27/22 was contacted. There were missed opportunities to gather collateral information from EMS and hospital staff regarding the fatality.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	FCDSS will contact, or make diligent efforts to contact, the source of all SCR reports so as to verify adequacy of report and possibly gain additional information. FCDSS will document the contact or attempts at contact.
Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	The father was the alleged subject in the duplicate report received on 11/27/22 with new allegations. The record did not reflect the father was interviewed regarding the allegations.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.
Issue:	Appropriateness of allegation determination
Summary:	The allegations of DOA/Fatality and L/B/W were inappropriately unsubstantiated. The record reflected the SC was not properly secured in his car seat as the straps were too tight and as a result, the child was strangled by them.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	FCDSS 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/22/2022 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 02:58 PM

County where fatality incident occurred: Fulton
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:

- [x] 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	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	No Role	Male	31 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Female	38 Year(s)
Other Household 1	Other Child - Cousin	No Role	Female	3 Year(s)
Other Household 1	Other Child - Cousin	No Role	Male	12 Year(s)
Other Household 1	Other Child - Cousin	No Role	Female	6 Year(s)
Other Household 2	Mother	No Role	Female	22 Year(s)
Other Household 3	Other Adult - Father of the 12yo Cousin	No Role	Male	35 Year(s)
Other Household 4	Other Adult - Father of the 3 & 6yo Cousins	No Role	Male	31 Year(s)

LDSS Response

On 9/23/22 FCDSS received a report regarding the death of the SC. FCDSS initiated their investigation within 24 hours and coordinated with law enforcement. FCDSS contacted the source of the initial report, completed a CPS history check regarding the family and informed the DA of the fatality. FCDSS assessed the safety of the aunt's children and conducted an initial home visit on 9/23/22. The record did not reflect the duplicate report that was received on 11/27/22 with new allegations regarding the father was addressed.

FCDSS interviewed all adults regarding the SC's death. The father had no concerns for the PA caring for the child during the week while he worked. The father was aware SC slept in his car seat and remained buckled in until he woke up. The father reported he allowed the SC to sleep, buckled in the car seat, regularly after picking up the SC from the PA. The PA reported she placed the SC in his car seat for a nap at 12:30PM. The SC was buckled in between the legs with a strap over each leg, and the center was buckled in the middle of the SC's chest where the shoulder straps met. The PA covered the SC with a blanket, gave him a sippy cup, placed the car seat in the center of the 12yo cousin's bedroom to nap and left the door open. The SC cried for a few minutes and when the PA checked on him about 10 minutes later, he was asleep. Around 1:45PM, the PA went to wake up the SC; she noticed the SC was lower in the car seat than normal and had slid down about a "head length", there was drool coming out of the SC's mouth and he was unresponsive. The record did not reflect if the family was aware of safe sleep recommendations or that the SC had access to a safe sleep environment.

FCDSS and LE interviewed the 6 and 12yo cousins who were at school when the fatal incident occurred, and they had no further information. FCDSS and LE attempted to interview the 3yo cousin, that was home the day of the fatal incident; however, they were unsuccessful. The children appeared to be free from any marks or bruises and were assessed as safe. The paternal grandmother was interviewed and reported she dropped off and picked up the SC at the PA's home when the

father worked. The paternal grandmother reported the SC did not like being in his car seat and would throw a tantrum before he would fall asleep. The mother was seen and interviewed, she reported she had not seen the SC on a consistent basis and had no concerns for the father's care of the child.

FCDSS spoke with the ME, who reported the death would be ruled as accidental. The ME confirmed the marks on the SC were consistent with the straps on the car seat. The final autopsy report was pending at the time this report was written. At the close of the investigation LE had not filed any criminal charges and the criminal case remained open pending the final autopsy report.

FCDSS spoke with the SC's pediatrician but missed an opportunity to follow up with collaterals such as EMS and hospital staff. FCDSS offered services to the father and the mother, and they declined. FCDSS offered the aunt grief counseling services and she accepted. It was unknown if the aunt was engaged in services at the close of the investigation. FCDSS appropriately substantiated the allegation of Inadequate Guardianship against the PA; however, the PA placed the SC in an unsafe sleeping environment with aggravating factors. The SC was in the car seat with the straps too tight. The SC died from asphyxia due to the compression of the neck with the car seat straps. The allegations of DOA/Fatality and L/B/W were unsubstantiated against the PA and should have been substantiated.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062558 - Deceased Child, Male, 1 Yrs	062562 - Aunt/Uncle, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
062558 - Deceased Child, Male, 1 Yrs	062562 - Aunt/Uncle, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
062558 - Deceased Child, Male, 1 Yrs	062562 - Aunt/Uncle, Female, 38 Year(s)	Lacerations / Bruises / Welts	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:

All relevant collateral sources were not interviewed. FCDSS missed opportunities to interview hospital staff and EMS. FCDSS were unsuccessful in their attempts to locate and interview the father of the 12yo sibling.

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: FCDSS offered the family burial assistance and they declined. Grief counseling was offered and the aunt accepted but it was unknown if she engaged with the services.				

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:
FCDSS offered grief counseling for the aunt's children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
FCDSS offered grief counseling and burial assistance to the family.

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

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)
11/05/2021	Other Child - 12 yo Cousin, Male, 11 Years	Aunt/Uncle, Female, 37 Years	Choking / Twisting / Shaking	Unsubstantiated	Yes
	Other Child - 12 yo Cousin, Male, 11 Years	Aunt/Uncle, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged on 11/5/21, the aunt choked the then 11-year-old cousin. It was unknown if the cousin sustained injuries.

Report Determination: Unfounded **Date of Determination:** 01/28/2022

Basis for Determination:
The allegations of Choking/Twisting/Shaking and Inadequate Guardianship were unsubstantiated. The family denied the

allegations. FCDSS did not find credible evidence to substantiate the allegations.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed timely. Written notice was provided to the adults. Home visits were made, and the children were assessed to be safe. The CPS history check was completed untimely. Collateral contacts were made.

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

Issue:
Review of CPS History

Summary:
The CPS history check was completed untimely on 11/12/21.

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/22/2021	Deceased Child, Male, 4 Months	Father, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 4 Months	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 4 Months	Father, Male, 30 Years	Other	Unsubstantiated	
	Deceased Child, Male, 4 Months	Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 4 Months	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 4 Months	Mother, Female, 21 Years	Other	Unsubstantiated	

Report Summary:
An SCR report alleged the mother had no diapers for the child. The mother asked others to provide formula and diapers for the child. The mother put the child in a baby swing and did not secure the child in properly. He fell out of the swing and hit his head. It was unknown if the child sustained any injuries. The father was aware that the child had no provisions and did not take steps to intervene.

Report Determination: Unfounded | **Date of Determination:** 11/30/2022

Basis for Determination:
The allegations of Inadequate Food/Clothing/Shelter and Inadequate Guardianship were unfounded. The investigation revealed the child fell out of the swing; however, had no visible marks or bruises. FCDSS documented the family had ample supplies for the child.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed timely. Written notice was provided timely. A home visit was made, and safe sleep recommendations were provided. A CPS history check was completed untimely. The father was not interviewed about the SCR report. There was not an ongoing assessment of safety and risk. Progress notes were untimely.

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

Issue:
Review of CPS History
Summary:
A CPS history check was completed untimely on 8/27/21.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. FCDSS 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:
The record did not reflect the father, who was an alleged subject, was interviewed regarding the SCR report dated 8/22/21.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
The Albany Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. FCDSS will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
There was a predetermination of safety and risk as the record did not reflect there was casework activity from 9/13/21-2/22/22. There were concerns the mother was unable to provide the SC with necessary provisions, such as formula and diapers.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
FCDSS 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:
Timely/Adequate Case Recording/Progress Notes
Summary:
Progress notes were not entered contemporaneously to their event dates. There were 13 out of 24 notes entered late, some up to 14 months after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

[redacted]

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

12/16/14- 2/9/15 The aunt was unsubstantiated for Inadequate Guardianship of the 12-year-old cousin.

11/10/16- 11/28/16 The paternal grandfather was unsubstantiated for Inadequate Guardianship and Lacerations/Bruises/Welts for the 12-year-old cousin.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Additional Local District Comments

DSS disagrees with NYS's assessment to indicate for DOA/Fatality.
Case was substantiated for PA for IG. No definitive evidence how tight the straps were when child was secured in the car seat. At the time of death, child's body was in a lower position than when placed in seat. Unlikely PA considered tight straps could lead to death. Child slept this way all the time without injury. Other family members used car seat similarly without problem. Public announcements of car seat safety highlight the need to make sure straps are tight. Unknown if child's failure to fit in car seat while police were at the autopsy stems from post-death conditions such as rigor mortis and bloating. Statement came from police not medical professional. PA showed appropriate parenting in other ways (open door, check on child, CPR). ME ruled death as accidental. Police didn't pursue. DSS based decision to unsubstantiate for fatality on discussion with workers who collected information firsthand providing a more nuanced, robust assessment than records alone.

DSS is repeatedly cited for failing to investigate and address allegations in a duplicate report. DSS takes issue with this criticism. The NYS Child Protective Services Manual defines Duplicate report as "A report of the same incident of suspected child abuse or maltreatment involving the same child(ren), subject and allegations previously reported to the SCR." The report's designation by the NYS SCR as a duplicate report indicates that there are no new allegations and lessened the attention given to the report.

DSS erred in not documenting officer's statement that there are no allegations of poisoning.

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