Child Fatality Report

Report Identification Number: AL-23-012

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

Issue Date: Nov 21, 2023

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

- [x] 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		

Child Fatality Report

Case Information

Report Type: Child Deceased | **Jurisdiction:** Rensselaer | **Date of Death:** 06/11/2023
Age: 8 month(s) | **Gender:** Female | **Initial Date OCFS Notified:** 06/11/2023

Presenting Information

The SCR report alleged that on 6/11/23, the subject child died while in the care of the mother and father. At approximately 9:00PM, the subject child was put to bed in an unknown location in the home. At approximately 10:00PM, the subject child was found unresponsive. The subject child was face-down and her lips were blue. Emergency medical services were notified at 10:05PM and arrived at the home at 10:09PM. The subject child was transported to the hospital and pronounced deceased at an unknown time. The subject child was an otherwise healthy child and the mother and father did not have an explanation for the subject child's death.

Executive Summary

This fatality report concerns the death of the 8-month-old female subject child that occurred on 6/11/23. The SCR report contained allegations of Inadequate Guardianship and DOA/Fatality against the mother and father. At the time of her death, the subject child resided with her mother and father. There were no surviving siblings or other children in the household.

Rensselaer County Department of Social Services (RCDSS) completed casework and collateral contacts and learned that on 6/11/23 the subject child returned home from a family friend’s residence shortly after 8:00PM. The father put the subject child in her crib at approximately 8:30PM with a 6-ounce bottle of formula. The father went to check on the subject child around 10:00PM and found her lips were blue and she was unresponsive. The father called 911 and was advised to perform cardiopulmonary resuscitation until emergency medical services arrived, which he did. Emergency medical services continued life-saving measures and transported the subject child to the hospital, where she was pronounced deceased at 10:53PM.

An autopsy was performed, and the final cause and manner of death were pending the toxicology results. The preliminary findings and death certificate reflect the subject child’s cause of death being asphyxiation due to or as a consequence of aspiration of gastric contents. The autopsy found that the subject child’s lungs were filled with food consistent with the last meal the subject child ate while in the care of the family friend. There were no signs of injury or trauma to the subject child.

Bereavement services were offered to the parents, and they were working with their respective healthcare providers to obtain grief counseling and mental health services. RCDSS also completed a referral for domestic violence services and ensured the parents had a list of substance abuse providers due to the parent's recent history of domestic violence and substance misuse. The allegations against the mother and father were unsubstantiated, as there was no evidence of abuse or maltreatment pertaining to the subject child’s death. The CPS investigation was unfounded and closed on 8/9/23.

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:**
    - **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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
RCDSS made an appropriate determination based on evidence obtained during their investigation.

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 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: 06/11/2023 **Time of Death:** 10:53 PM

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

County where fatality incident occurred:	Rensselaer
Was 911 or local emergency number called?	Yes
Time of Call:	10:05 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

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	Female	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)

LDSS Response

Upon receipt of the SCR report, RCDSS coordinated their investigation with LE, interviewed the parents and collateral sources, conducted a CPS history check, and offered fatality-related services.

RCDSS interviewed the SM and SF and learned that the SC spent the night at the MGM's residence two days prior to her death and spent the night preceding her death at the home of a family friend (FF). The SM was out of town with friends in the days preceding the SC's death and the SF was catching up on sleep. The SM reported Facetiming with the SC on 6/11/23, and she appeared happy and normal. The FF returned the SC to the parents around 8:22PM on 6/11/23, according to video footage obtained from the SM. The SF stated it was past the SC's bedtime, but they stayed up with her and played for a little while. The video showed the SF putting the SC in her crib at 8:31PM. The SF stated he made the SC a 6-ounce bottle because she seemed fussy and put the bottle in the crib with the SC. The SF stated he tucked the SC in with a blanket and reported seeing the SC standing on the monitor after leaving the room. The SC laid back down and the parents assumed she went to sleep, as they didn't hear or see anything else. At 10:02PM, the SF was seen entering the room and reported he was checking on the SC. The SF stated the SC was lying on her stomach with her face to the side, propped on her arm. When the SF touched the SC, he stated she was sweaty and warm. The SF moved the SC and stated she felt "lifeless", and when he picked the SC up, her head flopped backward. The SF noticed the SC's lips were blue and screamed for the SM. The SF called 911 and was advised to perform CPR until EMS arrived. EMS took over life-saving measures upon arrival; however, the SC was pronounced deceased at the hospital. The SF noted it appeared the SC did not drink any of the bottle's contents.

The FF was interviewed and reported the night of the SC's death was normal and the SC appeared fine. The FF stated the SC took a nap from 3:30PM until 6:45PM. After waking up, the FF gave the SC a bath and fed her dinner, which consisted of beef and vegetable baby food. The FF brought the SC home after 8:00PM and remained at the parent's home until around 9:00PM. The FF stated the parents were fighting, and she wanted to ensure they were calm before leaving. The FF could not recall the specifics of the fight. The FF sent the SM a photo of the baby food, which the SM stated the SC had before. The SM reported trusting the FF and denied any concern for the SC while in the FF's care. The FF did report that the SC defecated four times on the day of her death, and this was unusual. The MGM stated the SC had a little cough while in her care two days prior to her death, but that it was not concerning and there were no other issues.

Upon responding to the fatal incident, LE observed marijuana in the home but noted no sign the parents were impaired. The SM admitted to smoking marijuana and was observed on video smoking marijuana just prior to the SC's arrival home.

The SM reported alcohol and cocaine use in the days preceding the SC's death but not while the SC was in her care. The SF denied any substance or alcohol use on the night of the incident.

EMS and LE observed a blanket and stuffed animal in the SC's crib, which the SM and SF confirmed. The SF stated when he checked on the SC, nothing was obstructing her face or airway.

The parents reported no medical concerns for the SC, though the SM noted the SC had a "gagging issue" since birth. RCDSS obtained pediatric records for the SC which reflected she was up to date medically and there were no medical concerns. The SC was seen and treated by the pediatrician and hospital for multiple viral infections in 11/2022.

Official Manner and Cause of Death

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065238 - Deceased Child, Female, 8 Mons	065239 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
065238 - Deceased Child, Female, 8 Mons	065239 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
065238 - Deceased Child, Female, 8 Mons	065240 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated
065238 - Deceased Child, Female, 8 Mons	065240 - Father, Male, 23 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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☒	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☒	☐	☐	☐	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☒	☐	☐	☐	☐

Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
RCDSS offered the parents bereavement services. The parents were working with their respective healthcare physicians on counseling and MH services. RCDSS offered burial assistance; however, the parents received private assistance. A referral to DV services was made. The parents confirmed they had a provider list for substance misuse evaluations, but they were not engaged in any treatment.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to the SM and SF. The SM's physician was working to assist the SM with behavioral health services. The SF was prescribed an anti-depressant by his physician following the SC's death and was working to engage in grief counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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)
03/25/2023	Deceased Child, Female, 6 Months	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	Yes

	Deceased Child, Female, 6 Months	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
	Deceased Child, Female, 6 Months	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated
	Deceased Child, Female, 6 Months	Father, Male, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
The SCR report alleged that on 3/25/23, the SM repeatedly punched the SF in the presence of the SC. The SM was impaired to some degree due to alcohol misuse at the time.

Report Determination: Unfounded	**Date of Determination:** 06/07/2023

Basis for Determination:
RCDSS unsubstantiated the allegations. RCDSS reported the investigation revealed the SM and SF had ongoing verbal disputes and the disputes had not escalated to physical violence since 11/17/22; however, noted a DV incident from 4/8/23 that resulted in "minor physical contact." The SM and SF were reportedly intoxicated during a DV incident on 5/14/23. RCDSS noted that LE left the SC in the care of the parents, which indicated the parents were capable of caring for the SC. The parents admitted to alcohol use. The SM had positive drug screens for marijuana and the SF had positive screens for marijuana and cocaine. RCDSS discussed having a sober caretaker and no DV in the presence of the SC.

OCFS Review Results:
RCDSS initiated their investigation within 24 hours by conducting a home visit, assessing the safety of the SC, and interviewing the SM and SF about the allegations. The SC was not seen from 3/28/23 to 5/15/23 despite numerous safety factors being present that posed a risk to the SC including alcohol and substance misuse, and ongoing DV. The SM's drug screen results were not discussed with her for over a month and the record did not reflect the SF's results were discussed. The allegation of PD/AM against the SF was predetermined as his cocaine use was not explored. There were 14 out of 39 notes entered more than 30 days past their event date.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The SC was not seen or assessed from 3/28/23 to 5/15/23 despite the parents' positive drug screens, and ongoing DV incidents during that time, and the SC being under the age of 1 year old. There were safety factors documented regarding alcohol and substance misuse as well as DV in the presence of the SC, and safety was not continually assessed.

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

Action:
RCDSS must continue to gather information to reassess the 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:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
The SM's drug screen results were not addressed with her until 48 days after the test date. There was no record that the SF's results were discussed with him. The allegation of PD/AM against the SF was predetermined, as RCDSS did not explore the SF's cocaine use or what effect, if any, this had on the SC. A plan was not put in place until 6/6/23 that the SC would not be left alone with the SF.

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

Action:

The Albany Regional Office informed OCFS 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:
Timely/Adequate Case Recording/Progress Notes

Summary:
The record reflected that 14 out of 39 progress notes were entered more than 30 days past the event date.

Legal Reference:
18 NYCRR 428.5

Action:
The Albany Regional Office informed OCFS 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/18/2022	Deceased Child, Female, 1 Months	Mother, Female, 20 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 1 Months	Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 1 Months	Father, Male, 23 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 1 Months	Father, Male, 23 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The SCR report alleged on 11/18/22, the SM and SF were involved in a verbal argument in the kitchen, and it continued in the bedroom where it became physical. The SF proceeded to put his hands around the SM's neck and applied pressure. The incident took place in the presence of the SC, who was asleep in her crib next to their bed. The SC did not sustain any injuries as a result of the incident. The SM and SF were intoxicated during the incident.

Report Determination: Indicated | **Date of Determination:** 06/07/2023

Basis for Determination:
RCDSS substantiated the allegations against the SF. The investigation revealed the SF was intoxicated by alcohol when he physically assaulted the SM in the presence of the SC. The SF wrapped his hands around the SM's throat and applied pressure, while the SC was lying in the bedroom. At the time of the incident, there was an active refrain from OP against the SF in favor of the SM. The SF was arrested, and a full stay-away OP was put in place against the SF. There was documentation that further DV incidents occurred on 4/2/23, 4/8/23, and 5/14/23, with both the SM and SF listed as perpetrators. The SM had a positive drug screen for marijuana and the SF was positive for marijuana and cocaine.

OCFS Review Results:
RCDSS initiated their investigation within 24 hours by contacting the source of the report, conducting a home visit, assessing the safety of the SC, and interviewing the SM; however, the record did not reflect the SF was interviewed about the allegations until 3/25/23. There was no documented casework between 11/18/23 and 3/25/23 and the SC was not seen from 3/28/23 until 5/15/23 when a subsequent report came in. RCDSS became aware the SM and SF tested positive for substances on 4/4/23; however, did not address the results until 5/15/23. There were 13 out of 56 progress notes entered more than 30 days past their event date.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:

There was no casework activity documented from 11/18/22 to 3/25/23, and the SC was not seen from 3/28/23 to 5/15/23 despite the parents' positive drug screens, ongoing DV incidents during that time, and the SC being under the age of 1 year old. There were safety factors regarding alcohol and substance misuse as well as DV in the presence of the SC, and safety was not continually assessed. There was no record that the initial allegations from 11/18/22 were addressed with the SF until a subsequent report was received on 3/25/23, at which time he stated he did not remember the circumstances of the events from the initial incident.

Legal Reference:

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

Action:

RCDSS must continue to gather information to reassess the 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:

Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:

RCDSS learned on 4/4/23 that the SM had a positive drug screen for marijuana and the SF had a positive drug screen for marijuana and cocaine. RCDSS attempted a phone call on 4/12/23; however, did not make contact and the record does not reflect the results were addressed until 5/15/23. The record did not reflect that RCDSS addressed the OP that was in place against the SF.

Legal Reference:

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

Action:

The Albany Regional Office informed OCFS 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:

Timely/Adequate Case Recording/Progress Notes

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The record reflected that 13 out of 56 progress notes were entered more than 30 days past the event date.

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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 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?

☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: 11/17/2022	**To:** 06/13/2023
Explain: There was an active refrain from OP against the SF in favor of the SM due to recent DV incidents that resulted in LE intervention and the SF being arrested.	

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