Child Fatality Report

Report Identification Number: AL-23-014

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

Issue Date: Dec 20, 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: 7 month(s)
Jurisdiction: Albany
Gender: Female
Date of Death: 07/09/2023
Initial Date OCFS Notified: 07/09/2023

Presenting Information

An SCR report received on 07/09/23 alleged that on 07/04/23, at approximately 11:00 PM, the mother put the 7-month-old child in a Pack 'N Play to sleep. The mother checked on the child between 1:30 AM-2:00 AM and realized the child was lethargic and had labored breathing. The mother placed the child in front of a fan to provide the child with an increased airflow, performed chest compressions and called 911. EMS transported the child to the hospital, and she received oxygen. Upon further evaluation, it was determined that while in the care of the mother, the child sustained an anoxic brain injury and swelling to the brain. On 07/09/23, the child was pronounced deceased at 11:50 AM. The mother did not have an explanation for the injuries that contributed to the child's death. The SCR report was subsequent to a report received on 07/05/23, concerning the fatal incident.

Executive Summary

This fatality report concerns the death of the 7-month-old child that occurred on 07/09/23. A report was made to the SCR on the same day alleging the child sustained an anoxic brain injury and swelling to the brain while in the care of the mother and subsequently died. At the time of the death, the child resided with her mother and 3-year-old sibling. On the night of the fatal incident, the mother's friend was in the home. The friend had a 1-year-old child. Albany County Department of Children Youth and Families (ACDCYF) created a safety plan for the 3-year-old sibling and the friend's child to stay with relatives while the child's injuries were investigated. The father had a 2-year-old child who resided in another state. Attempts were made to assess her safety to no avail.

ACDCYF coordinated investigative efforts with law enforcement upon receipt of the SCR report that concerned the fatal incident. The outcome of the criminal investigation remained unknown. A law enforcement officer reported the preliminary autopsy "indicated a natural cause of death" and that the child had a respiratory infection which resulted in a fever that caused a seizure. The results of the autopsy report remained unknown.

The mother was interviewed and reported the child acted fine on 07/04/23 and that she was sleeping in a Pack 'N Play. The mother checked on the child and noticed she looked pale, and something was not right. The mother called 911 as the child was barely breathing and appeared to be attempting to catch her breath. First responders arrived and transported the child to the hospital where she was on life support until she died.

ACDCYF contacted collaterals including hospital staff and family members. Hospital staff reported the child was in critical condition upon arrival to the hospital and that she displayed signs of a brain injury. Exams revealed the child's injury was caused by a lack of oxygen. If the child survived, she would have permanent brain damage. While the child was hospitalized, her condition worsened, and she died. Family members did not have concerns for the care the mother provided to the child or the sibling.

After information was received that the child was suspected to have died due to natural causes, the safety plan was lifted, and the children were returned to their respective parents.

The allegations of Inadequate Guardianship, Internal Injuries, Swelling/Dislocations/Sprains and DOA/Fatality were unsubstantiated. The Investigation Conclusion Narrative stated that the mother was unable to provide an explanation for the child's injuries and subsequent death. The preliminary autopsy report revealed the child died of natural causes. A fair preponderance of evidence to support the allegations was not revealed.

ACDCYF completed the Safety Assessments and required reports timely and accurately. Familial and collateral contacts were made and documented appropriately. The case was appropriately determined and was closed on 09/20/23. ACDCYF offered grief services to the family; it remained unknown if the father utilized the services. The mother was engaged in therapy.

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 issues. For issues where a PIP is currently implemented as a result of a prior finding by OCFS, ACDCYF will continue to review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:

The decision to close the case was appropriate.

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 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: 07/09/2023 **Time of Death:** 11:50 AM

Date of fatal incident, if different than date of death: 07/04/2023
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Albany
Was 911 or local emergency number called? Yes
Time of Call: 03:38 AM
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	7 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Other Household 1	Father	No Role	Male	30 Year(s)

LDSS Response

On 07/05/23, ACDCYF received a report from the SCR regarding the fatal incident and immediately began their investigation. ACDCYF notified law enforcement of the alleged physical injuries to the child and began gathering information from hospital staff and family members. After the receipt of the SCR report regarding the death, ACDCYF continued their investigation and met all 24-hour requirements.

A doctor stated the child was brought to the hospital for bronchitis, but the doctor noticed the child's "arms were twisted," indicating a brain injury. The child had a global anoxic brain injury, also affecting her kidneys, pancreas, and intestines. The doctor noted it was believed the child's brain injury happened hours before she was brought to the hospital. The brain

injury was caused by a lack of oxygen, and as a result, the child would have permanent damage and her condition was life-threatening.

The mother was interviewed at the hospital on 07/05/23. She stated that approximately 2 months prior, she brought the child to the emergency room for gasping and wheezing. The child was diagnosed with an upper respiratory infection. The mother was advised to provide the child with Tylenol. The child stopped gasping but wheezed a week prior to the fatal incident. The mother scheduled a follow-up appointment for the child; however, missed the appointment. The mother rescheduled the appointment for 07/12/23. On 07/05/23, the child was sleeping on her back in a Pack 'N Play with a "giraffe" at her feet around 1:00 AM. The child's arms were "jerking" at that time. At approximately 3:30 AM, the mother checked on the child and she realized something was wrong with the child as she was not making her usual noises while sleeping. The mother looked at the child, and she was pale and barely breathing, and appeared to be attempting to catch her breath. The mother denied knowing how the child sustained her injury, but noted around 06/30/23, she bumped the child's head on the sink while bathing her but did not think it was concerning.

The mother's friend reported that on the day of the fatal incident, she woke to a text from the mother saying that the mother had to perform CPR on the child, called EMS and the child was blue and losing oxygen. The mother's friend denied seeing or hearing anything of concern and did not wake up after the mother found the child unresponsive. The friend reported last seeing the child on 07/04/23, around 10:00 PM, and the child cried and then fell asleep. The child appeared happy and normal in the days prior. The friend did not have concerns for the care the mother provided to the child or sibling.

ACDCYF interviewed family members including the maternal grandfather, maternal aunt and uncle and the father. There were no concerns for the safety of the child or sibling. The grandfather reported the mother took good care of her kids, as did the maternal aunt. The father expressed that the mother was not a violent person and that she would not harm the child. On the day before the fatal incident, he said the child appeared fine and that she did not have breathing issues.

After ACDCYF learned from law enforcement that the child was suspected to have died of natural causes, the safety plan was lifted, and the sibling and the friend's child returned to their care.

ACDCYF documented appropriate casework activity and completed all requirements prior to closing the case.

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? Yes
Comments: The death was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065525 - Deceased Child, Female, 7	065549 - Mother, Female, 26	DOA / Fatality	Unsubstantiated

Month(s)	Year(s)		
065525 - Deceased Child, Female, 7 Month(s)	065549 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
065525 - Deceased Child, Female, 7 Month(s)	065549 - Mother, Female, 26 Year(s)	Internal Injuries	Unsubstantiated
065525 - Deceased Child, Female, 7 Month(s)	065549 - Mother, Female, 26 Year(s)	Swelling / Dislocations / Sprains	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☐	☒
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: Appropriate services were offered.				

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Family members assisted the family in carrying out the safety plan.

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 mother was provided with referrals for grief counseling. It remained unknown if the sibling would benefit from the service, or if she was engaged in therapy.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The father was mailed a referral for grief services. The mother was engaged in counseling.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Had heavy alcohol use
☐ Misused over-the-counter or prescription drugs
☐ Smoked tobacco

☐ Experienced domestic violence
☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ 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)
07/05/2023	Deceased Child, Female, 7 Months	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 7 Months	Mother, Female, 26 Years	Internal Injuries	Unsubstantiated	

Report Summary:
An SCR report alleged on 07/05/23, the 7-month-old child was diagnosed with a severe anoxic brain injury, which was typically a result of lack of oxygen to the brain. The mother's explanation that the child hit her head on a sink 3 days prior was inconsistent with the nature of the injury.

Report Determination: Unfounded | **Date of Determination:** 11/14/2023

Basis for Determination:
The Investigation Conclusion Narrative stated the allegations were unsubstantiated. Family members and the mother's friend did not report concerns for the mother's care of the child or sibling. There was not a fair preponderance of evidence to support the allegations of the report.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check was documented timely. Law enforcement was notified. The 7-day Safety Assessment was completed timely. Home visits were made. Family members and collateral contacts were interviewed. The record reflected gaps in casework activity. The investigation was closed untimely on 11/14/23.

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

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

Summary:
The record reflected gaps in casework activity. There was not documented contact with the family from 07/06/23-09/07/23. A home visit was made on 09/08/23 when the mother and sibling were seen. There was no contact with the mother until 11/14/23 and the case was closed without assessing the sibling face-to-face since 09/08/23.

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

Action:
ACDCYF will make 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 as safety and risk are not static.

Date of SCR	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

Report					
06/17/2022	Sibling, Female, 2 Years	Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Sibling, Female, 2 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the mother, and then 2-year-old sibling were living out of a car. The mother did not go to work for 2 days as the sibling was sick and therefore was unable to go to daycare. The mother did not provide a safe and stable environment for the sibling.

Report Determination: Unfounded | **Date of Determination:** 08/16/2022

Basis for Determination:
The Investigation Conclusion Narrative stated that the mother and sibling were staying in a hotel as there was DV perpetrated by the father. Prior to living in a hotel, the family was evicted for not paying rent. The father reported he did not know where the mother and sibling resided. The sibling was observed to be healthy and free from visible marks or bruises.

OCFS Review Results:
The case was initiated timely, and a CPS history check was documented. The source was contacted, and a home visit was made. Collaterals were contacted and the parents were interviewed. The 7-day Safety Assessment and Risk Assessment Profile were completed with accuracy. The mother was provided with assistance in obtaining housing.

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)
05/18/2021	Other Child - Cousin, Male, 1 Years	Aunt/Uncle, Female, 18 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Other Child - Cousin, Male, 1 Years	Aunt/Uncle, Female, 18 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Cousin, Male, 1 Years	Aunt/Uncle, Female, 18 Years	Lack of Medical Care	Unsubstantiated	
	Other Child - Unnamed Child, Female, 4 Months	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unnamed Child, Female, 4 Months	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Unnamed Child, Female, 4 Months	Unrelated Home Member, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unnamed Child, Female, 4 Months	Unrelated Home Member, Male, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged the aunt did not adequately feed the 1-year-old cousin and he missed meals and went hungry as a result. The aunt did not ensure the cousin was adequately bathed, leaving him dirty, and he had soiled diapers. The cousin had skin issues that required treatment and the aunt failed to seek adequate medical attention. A subsequent report received on 06/10/21 alleged the mother and unrelated home member smoked marijuana to the point of impairment while caring for the 3-year-old unnamed child. The drug was left accessible to the 3-year-old, and it remained unknown if the 3-year-old ingested the drug.

Report Determination: Unfounded | **Date of Determination:** 02/20/2022

Basis for Determination:
The allegations were unsubstantiated. The Investigation Conclusion Narrative stated the aunt reported the cousin had a skin condition and she applied ointments as prescribed, and the cousin was medically assessed as necessary. The aunt reported the cousin had ample food. The cousin was observed and appeared to have a quarter-sized rash on his cheek that did not appear to be infected.

OCFS Review Results:
The investigation was initiated timely, and a home visit was made. The record did not reflect attempts to contact the mother, siblings, or the fathers of the children. A CPS history check was untimely and incomplete. There was no documented casework activity for nearly 9 months. The 7-day Safety Assessment was completed timely. A medical collateral contact was made. The allegations of the subsequent SCR report were not addressed. Written notice was not provided. The Investigation Conclusion Narrative did not address the allegation of PD/AM.

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

Issue:
Review of CPS History
Summary:
Although a CPS history check was documented, it was completed untimely on 02/20/22. The CPS history check did not include the mother, who was an alleged subject of the subsequent SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. The Albany Regional Office will continue to work on this issue with ACDCYF 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 interviews with the fathers of the children or the mother. There were not documented attempts to identify or interview the unrelated home member or the unnamed child on the subsequent report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. The Albany Regional Office will continue to work on this issue with ACDCYF and revise their current PIP if deemed necessary.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
The investigation was inadequate overall. The record did not reflect the allegations of the subsequent report were addressed. There were no documented attempts to identify an alleged subject or children on the report. The sibling was not documented to have been considered to be the alleged maltreated child.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
ACDCYF will review and adhere to regulations regarding casework practice in general. ACDCYF will make contact with alleged subjects, collaterals, and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

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

Summary:
There was a predetermination of safety and risk as there was no documented casework activity between 05/27/21-02/18/22.

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

Action:
ACDCYF will make 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.

[redacted]

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

The is no known CPS history outside of New York.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No