# Child Fatality Report

## Report Identification Number: NY-23-116

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

## Issue Date: Apr 22, 2024

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 | | |

# Child Fatality Report

## Case Information

**Report Type:** Child Deceased
**Age:** 3 year(s)
**Jurisdiction:** Queens
**Gender:** Male
**Date of Death:** 11/29/2023
**Initial Date OCFS Notified:** 11/30/2023

### Presenting Information

An SCR report alleged the parents and grandparents were aware the 3-year-old child was diagnosed with a developmental disorder and a neurological disorder requiring a higher level of care. On 11/29/23, around 6:20 PM, the parents and grandparents were walking down a busy street with the child in one of their arms. The adult put the child down and no one ensured the child was held on to. The child got away from the adults and ran into traffic where he was struck by a car in a hit and run accident. The adults ran to the child and the father grabbed him. The father started CPR and 911 was called. EMS arrived at 6:49 PM and CPR was continued on the way to the hospital. Lifesaving measures were attempted; however, the child was pronounced deceased at 7:39 PM due to cardiopulmonary arrest caused by hemorrhage shock.

### Executive Summary

This report concerns the death of the 3-year-old child that occurred on 11/29/23. A report was made to the SCR the following day alleging the child was not properly supervised when he ran into the road and was struck by a car. The child died as a result of his injuries. At the time of his death, the child resided with his paternal grandparents. The mother and father resided together in another residence. There were no surviving siblings or other children.

The Administration for Children's Services (ACS) coordinated investigative efforts with law enforcement. The progress notes reflected the driver of the vehicle that struck the child was charged with leaving the scene of an accident with a fatality and driving without a license. The Investigation Conclusion Narrative reflected the driver was arrested for manslaughter. An autopsy was performed, and the cause of death was "blunt trauma of head and neck". The manner of death was listed as an accident (pedestrian struck by motor vehicle).

The grandmother and mother reported the father was caring for the child when he was struck by a vehicle and the driver fled the scene. It remained unknown who called 911. EMS arrived and transported the child to the hospital where he was pronounced deceased.

The record noted an attempt to contact the father via phone to no avail. An attempt to call the grandfather was not documented. Although an unsuccessful home visit was made, the record did not reflect further attempts to interview the grandfather or father, who were subjects of the report. Although ACS documented a telephone interview with the grandmother, she was not documented to have been seen face-to-face. Additionally, although the mother provided times when she would be available to be interviewed face-to-face, the record did not reflect an in-person interview occurred. The record inaccurately reflected "the parents refused to meet and speak with CPS."

ACS gathered collateral information from hospital staff, a law enforcement officer, and the medical examiner. The record did not reflect attempts to contact collateral contacts who may have had information regarding the level of supervision that was typically provided to the child.

The required reports were completed timely and accurately. Although information was gathered from the mother that the names of the parents listed on the report were inaccurate, ACS did not update the identifying information for either parent in Connections.

ACS unsubstantiated the allegations. The Investigation Conclusion Narrative contained information that was not

documented elsewhere in the case record. The Investigation Conclusion Narrative stated the child was walking in front of the father when the child walked in front of a vehicle that was double-parked. The driver of the vehicle began to pull away and "ran over" the child before fleeing.

The mother and grandmother were offered burial assistance and bereavement services. The mother declined the services. The case was closed timely on 12/20/23.

**PIP Requirement**

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS 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:**

The case was appropriately determined.

**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 was not commensurate with case circumstances as subjects of the report were not interviewed. The case record did not accurately reflect accurate names or other demographic information.

### Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Case record contains information that is relevant, useful, factual and objective |
| **Summary:** | ACS did not update the names of the parents or their demographic information, including their dates of birth in Connections. The mother's name was inaccurately documented in the person list. The |

| | |
|---|---|
| | father's name was listed as the mother's name. |
| **Legal Reference:** | 18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1) |
| **Action:** | ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. |
| | |
| **Issue:** | Failure to Conduct a Face-to-Face Interview (Subject/Family) |
| **Summary:** | The record reflected the SM was willing to meet face-to-face, yet the case was closed without doing so. The record did not reflect an attempt to call the PGF. The SF, PGF nor the SM were interviewed face-to-face. |
| **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. |
| | |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 11/29/2023 **Time of Death:** 07:39 PM

**Time of fatal incident, if different than time of death:** 06:35 PM

**County where fatality incident occurred:** Queens
**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?** No
**Child's activity at time of incident:**

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Pedestrian

**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 | 3 Year(s) |
| Deceased Child's Household | Grandparent | Alleged Perpetrator | Male | 61 Year(s) |
| Deceased Child's Household | Grandparent | Alleged Perpetrator | Female | 59 Year(s) |

| | | | | |
|---|---|---|---|---|
| Other Household 1 | Father | Alleged Perpetrator | Male | 43 Year(s) |
| Other Household 1 | Mother | Alleged Perpetrator | Female | 33 Year(s) |

## LDSS Response

On 11/30/23, ACS received the fatality report from the SCR. Within the first 24 hours of the investigation, ACS coordinated investigative efforts with law enforcement, notified the medical examiner and district attorney's offices of the death, completed a CPS history check, and contacted the source of the report.

Hospital staff reported that the parents and grandparents were present at the time the child ran into the street and was struck by a vehicle. The parents called 911 and EMS transported the child to the hospital where he was pronounced deceased.

On 11/30/23, ACS spoke with the mother over the phone. She reported that the child was with the father when he was struck by a vehicle. The grandparents arrived approximately 3 minutes after the incident. She did not provide further information regarding the accident.

On 11/30/23, a call was placed to the grandmother. She reported that on the day of the fatal incident, she received a call from the father saying the child was hit by a vehicle. The grandmother went to the scene of the accident and held the child until EMS arrived. She reported that the child was on the sidewalk at the time he was struck, and that the driver fled the scene.

The father nor grandfather were interviewed. Although a home visit was made, and the grandfather was asleep, diligent attempts were not made to interview him thereafter. The record did not reflect an interview with the father.

A law enforcement officer reported the driver was arrested in relation to the fatality and he did not suspect charges would be filed against the parents. The officer reported the case was considered "pedestrian error" as the child ran in front of the vehicle; however, noted it was illegal to leave the scene of an accident. The driver was arrested for "leaving the scene of an accident with a fatality" and driving without a license. The officer anticipated the driver could be charged with manslaughter.

Information was gathered from the medical examiner who reported the child had a blunt force trauma to the head, multiple skull fractures, brain bleeds and an internal decapitation. The medical examiner reported there was "devastating trauma on the neck" and that the child sustained a fracture to his right arm and left leg. The injuries were consistent with that of the car accident.

ACS unsubstantiated the allegations against the parents and grandparents. The Investigation Conclusion Narrative stated there was not enough evidence to substantiate the allegations and noted that "CPS has no legal basis to speak with the family as there are no surviving children and this was a tragic accident." Additionally, ACS inaccurately documented that the parents refused to speak with them.

## Official Manner and Cause of Death

**Official Manner:** Accident
**Primary Cause of Death:** From an injury - external cause
**Person Declaring Official Manner and Cause of Death:** Medical Examiner

## Multidisciplinary Investigation/Review

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

**Was the fatality referred to an OCFS approved Child Fatality Review Team?** No
**Comments:** The New York City Region does not have an OCFS-approved Child Fatality Review Team.

**SCR Fatality Report Summary**

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 066845 - Deceased Child, Male, 3 Year(s) | 066846 - Grandparent, Male, 61 Year(s) | DOA / Fatality | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066846 - Grandparent, Male, 61 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066846 - Grandparent, Male, 61 Year(s) | Internal Injuries | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066848 - Mother, Female, 33 Year(s) | DOA / Fatality | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066848 - Mother, Female, 33 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066848 - Mother, Female, 33 Year(s) | Internal Injuries | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066847 - Grandparent, Female, 59 Year(s) | DOA / Fatality | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066847 - Grandparent, Female, 59 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066847 - Grandparent, Female, 59 Year(s) | Internal Injuries | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066849 - Father, Male, 43 Year(s) | DOA / Fatality | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066849 - Father, Male, 43 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 066845 - Deceased Child, Male, 3 Year(s) | 066849 - Father, Male, 43 Year(s) | Internal Injuries | 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?**

☐Family Court ☒Criminal Court ☐Order of Protection

| **Criminal Charge:** Other - Leaving the scene of an accident with a fatality. | | **Degree:** NA | |
|---|---|---|---|
| **Date Charges Filed:** | **Against Whom?** | **Date of Disposition:** | **Disposition:** |
| Unknown | The driver | Unknown | Unknown |
| **Comments:** | The driver was arrested for leaving the scene of an accident and driving without a license. It remained unclear if the driver was charged with manslaughter. | | |

## 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 parent(s) and other care givers to address any immediate needs related to the fatality?** Unable to Determine
**Explain:**
Referrals for bereavement services and funeral assistance were offered to the family; however, it remained unknown if the family utilized the services.

## 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

## 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) |
|---|---|---|---|---|---|
| 08/23/2022 | Deceased Child, Male, 2 Years | Mother, Female, 31 Years | Inadequate Guardianship | Unsubstantiated | No |
| | Deceased Child, Male, 2 Years | Mother, Female, 31 Years | Lack of Medical Care | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Grandparent, Male, 60 Years | Inadequate Guardianship | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Grandparent, Male, 60 Years | Lack of Medical Care | Unsubstantiated | |

**Report Summary:**
An SCR report alleged the SC had a reconstructive surgery. It was highly recommended that the SM and PGF follow post-operative care instructions. The PGF and SM were aware but failed to follow through with ensuring the SC had

medication and appropriate wound care. The SC's wellbeing would deteriorate without appropriate intervention.

**Report Determination:** Unfounded | **Date of Determination:** 09/27/2022

**Basis for Determination:**
The allegations were unsubstantiated. The Investigation Conclusion Narrative stated that there was not a fair preponderance of evidence to support the allegations. The SC attended follow up appointments and medical staff reported that the SC was healing well and there were no concerns. The parents resided out of state and did not regularly care for the SC.

**OCFS Review Results:**
The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed timely, and accurately. A CPS history check was completed timely. Relevant collateral contacts were made. The SC was referred to Early Intervention services. Attempts were made to contact the parents. The SM resided out of state and was not a caregiver to the SC.

**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) |
|---|---|---|---|---|---|
| 07/05/2022 | Deceased Child, Male, 2 Years | Mother, Female, 32 Years | Inadequate Guardianship | Unsubstantiated | No |
| | Deceased Child, Male, 2 Years | Grandparent, Male, 60 Years | Inadequate Guardianship | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Grandparent, Female, 57 Years | Inadequate Guardianship | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Father, Male, 42 Years | Inadequate Guardianship | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Aunt/Uncle, Male, 30 Years | Inadequate Guardianship | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Aunt/Uncle, Female, 27 Years | Inadequate Guardianship | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Grandparent, Female, 57 Years | Inadequate Food / Clothing / Shelter | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Aunt/Uncle, Female, 27 Years | Inadequate Food / Clothing / Shelter | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Grandparent, Female, 57 Years | Swelling / Dislocations / Sprains | Unsubstantiated | |
| | Deceased Child, Male, 2 Years | Aunt/Uncle, Female, 27 Years | Swelling / Dislocations / Sprains | Unsubstantiated | |

**Report Summary:**
An SCR report alleged the PA and PGM were the primary caretakers of the SC. The adults only fed the SC milk despite being told that he needs to eat more protein. The SC was thin, was not growing and lacked energy as a result. A subsequent report alleged the SM, PGM and PA argued in the presence of the SC. In November 2021, the PGM and PA cut the SC's hair and injured his nose and head. The PGF, PU, SM and SF were aware but did not intervene. On 06/24/22, the PGM and PA again cut the SC's hair in patches to upset the SM.

**Report Determination:** Unfounded | **Date of Determination:** 07/20/2022

**Basis for Determination:**
The allegations were unsubstantiated. The Investigation Conclusion Narrative stated marks were not observed on the SC

and there was ample food in the home. The pediatrician did not have concerns for the SC or his weight. The adults reported the SC had a mark on him in November 2021, and the SM contacted EMS and they did not have concerns for the SC.

**OCFS Review Results:**
The investigation was initiated timely, and the sources were contacted. The 7-day Safety Assessment was completed timely and accurately. Home visits were made, the family was interviewed, and collaterals were contacted. A CPS history check was documented.

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

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

There was no CPS investigative history more than three years prior to the fatality.

## Known CPS History Outside of NYS

There 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