# Child Fatality Report

## Report Identification Number: SV-22-031

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

**Issue Date: Jan 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 has an open 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 month(s)
**Jurisdiction:** Westchester
**Gender:** Male
**Date of Death:** 08/12/2022
**Initial Date OCFS Notified:** 08/12/2022

### Presenting Information

An SCR report alleged on 8/11/22, the mother fed the 1-month-old 3 ounces of formula at an unknown time in the evening. The mother put the child into a crib sometime between 11:00 PM -12:30 AM. The crib contained unsafe items such as bumpers, pillows, and stuffed animals. The mother did not check on the child until 6:00 AM on 8/12/22. At that time, the mother found the child unresponsive. The child was laying on his side and stomach near the crib's wall, with his face close to the bumpers. Another adult called 911 while the mother started CPR. When LE arrived, they took over resuscitation efforts. The child was transported to the hospital where he was pronounced deceased at 6:35 AM. The child was in the care of the mother, father, and two adult siblings at the time of the death; therefore, they were named as alleged subjects. Two duplicate reports were made to the SCR on 8/13/22.

### Executive Summary

This fatality report concerns the death of the 1-month-old child that occurred on 8/12/22. A report was made to the SCR on the same day and 2 duplicate reports were made the following day. The reports had allegations that the child was discovered in an unsafe sleeping environment and subsequently passed away. At the time of his death, the child resided with his mother, 9-year-old sibling, and 2 adult siblings. The 9-year-old sibling was assessed to be safe with the parents. The father had a 14-year-old child; however, the record did not reflect further information was gathered about her or her safety.

Westchester County Department of Social Services (WCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. An autopsy was performed, and the manner of death was an accident. The cause of death was “suffocation of an 8-week-old infant in crib due to unsafe sleep in crib with crib bumpers, soft pillows, blankets, and stuffed animals”. The pathologist documented that the child was “positioned on side and face into crib bumper”. The law enforcement investigation remained open at the time the WCDSS determined their investigation.

The mother reported that she laid the child down to sleep in his crib and she found him “barely alive” approximately 5 hours later. An adult sibling called 911; however, it remained unknown which of the adult siblings called. Law enforcement officers arrived and took over resuscitation efforts until EMS arrived and transported the child to the hospital where he was pronounced deceased. The father did not reside in the home and was not present at the time of the fatal incident.

WCDSS gathered collateral information from the younger adult sibling and the pediatrician. The record did not reflect the younger adult sibling had concerns for the care of the child. The pediatrician reported the child was growing and developing well.

WCDSS completed required reports and Safety Assessments timely. The record noted that the eldest sibling did not make himself available to address the allegations of the report; however, he was observed on two occasions, and he was not interviewed. Although attempts were made to interview the 9-year-old sibling, the record did not reflect the sibling was interviewed regarding overall safety and risk factors.

The allegations against the mother were substantiated. WCDSS based their determination on the information that was gathered from the medical examiner’s office that the child was found in an unsafe sleeping environment that contained pillows, a crib bumper, stuffed animals, and blankets. Subsequently, the medical examiner determined the cause of death

was a result of the unsafe sleeping environment. The allegations were unsubstantiated against the adult siblings and the father as they did not have caretaking responsibilities for the child. There was conflicting information documented in the Investigation Conclusion Narrative as it stated that the siblings were not home at the time of the fatal incident; however, it also stated that the younger adult sibling was present at the time of the death and heard the mother calling out for the adult siblings to help. The investigation was closed timely on 10/11/22.

**PIP Requirement**
WCDSS will submit a PIP to the Westchester Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the WCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, WCDSS 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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

**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 case circumstances as there were missed opportunities to gather information regarding the death, and the overall safety and risk factors regarding the 9-year-old sibling.

### Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Failure to Conduct a Face-to-Face Interview (Subject/Family) |
| **Summary:** | The record noted the eldest adult SS was seen twice, yet the record did not reflect attempts to |

| | |
|---|---|
| | interview him; there were missed opportunities to gather information from him. The 9yo SS was not interviewed regarding all safety and risk factors. |
| **Legal Reference:** | 18 NYCRR 432.2(b)(3)(ii)(a) |
| **Action:** | WCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations. |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 08/12/2022 **Time of Death:** 06:35 AM

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

**County where fatality incident occurred:** Westchester
**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 alcohol or drugs?** N/A
**Child's activity at time of incident:**

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

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

### Household Composition at time of Fatality

| Household | Relationship | Role | Gender | Age |
|---|---|---|---|---|
| Deceased Child's Household | Deceased Child | Alleged Victim | Male | 1 Month(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 40 Year(s) |
| Deceased Child's Household | Sibling | Alleged Perpetrator | Male | 22 Year(s) |
| Deceased Child's Household | Sibling | Alleged Perpetrator | Male | 18 Year(s) |
| Deceased Child's Household | Sibling | No Role | Male | 9 Year(s) |
| Other Household 1 | Father | Alleged Perpetrator | Male | 45 Year(s) |

### LDSS Response

On 8/12/22, WCDSS received the fatality report from the SCR. Two duplicate reports were made the following day. Within the first 24 hours of the investigation, WCDSS coordinated investigative efforts with law enforcement, contacted the sources of the reports, notified the district attorney's office of the death, and documented a CPS history check. The medical examiner's office was aware of the death.

The father was interviewed at his home. He reported that he was not at the mother's home at the time of the fatal incident. The father stated that on the day of the death, he and the 9-year-old sibling left the mother's home around 5:00 AM and the sibling went to the paternal grandmother's home while the father worked. While the father was working, he received a call from one of the adult siblings notifying him that something happened to the mother. The adult sibling came to the father's place of employment and brought him to the hospital, where the father learned that the child was deceased. The father did not have information regarding the death. The father said the child would sleep in a crib; however, the father was unaware of safe sleep recommendations or how the child was positioned while the child slept.

On 8/17/22, the 9-year-old sibling was observed at the father's home. The sibling reported feeling safe with the father and that the child appeared to be fine on the day prior to the death.

On 8/19/22, the mother was interviewed face-to-face. She reported that on the day prior to the death, she fed the child and then placed him to sleep in his crib between 11:30 PM and 12:00 AM. Between 5:00 AM- 5:30 AM, the mother checked on the child and found him "barely alive". She panicked, called out for one of the adult siblings and she performed CPR until first responders arrived and took over. During the home visit, WCDSS observed the child's crib to have a crib bumper, and a few stuffed animals. The mother denied that the child's face was against the bumper or that his breathing was obstructed when she found him. The younger adult sibling reported he was asleep when the mother screamed. He was unaware of any details surrounding the fatal incident.

A law enforcement officer reported possible marijuana use at the home. Although the mother denied using drugs, the record did not reflect other adults, nor the 9-year-old sibling were interviewed regarding the alleged drug use. WCDSS contacted the child's pediatrician. The pediatrician did not note any concerns for the care or health of the child.

In response to the death, the family was offered burial assistance and a grief counseling referral that were accepted. The father was undecided if he wanted to engage in bereavement services. The mother was offered mental health services and grief counseling, which she accepted; however, it remained unknown if the mother engaged in the counseling services.

## 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:** Other physician

## 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 |
|---|---|---|---|
| 062321 - Deceased Child, Male, 1 Mons | 062323 - Sibling, Male, 22 Year(s) | DOA / Fatality | Unsubstantiated |
| 062321 - Deceased Child, Male, 1 Mons | 062323 - Sibling, Male, 22 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 062321 - Deceased Child, Male, 1 Mons | 062324 - Sibling, Male, 18 Year(s) | DOA / Fatality | Unsubstantiated |
| 062321 - Deceased Child, Male, 1 Mons | 062324 - Sibling, Male, 18 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 062321 - Deceased Child, Male, 1 Mons | 062326 - Father, Male, 45 Year(s) | DOA / Fatality | Unsubstantiated |
| 062321 - Deceased Child, Male, 1 Mons | 062326 - Father, Male, 45 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 062321 - Deceased Child, Male, 1 Mons | 062322 - Mother, Female, 40 Year(s) | DOA / Fatality | Substantiated |
| 062321 - Deceased Child, Male, 1 Mons | 062322 - Mother, Female, 40 Year(s) | Inadequate Guardianship | Substantiated |

## 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?** | ☒ | ☐ | ☐ | ☐ |

**Additional information:**

The eldest adult sibling, who was a subject of the report, was not interviewed.

## 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 | ☐ | ☐ | ☐ | ☒ |

## 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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality? | ☐ | ☒ | ☐ | ☐ |
| **Explain as necessary:**<br>No children needed to be removed as a result of the fatality investigation. | | | | |

## Legal Activity Related to the Fatality

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

**Services Provided to the Family in Response to the Fatality**

| Services | Provided 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:**
It remained unknown if the minor sibling was engaged in the grief services.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
The record reflected the parents were offered grief counseling in response to the services. The father was undecided if he wanted to attend counseling. The mother accepted the service; however, it remained unknown if she participated. The record did not reflect the adult siblings were provided with referrals in response to the death.

## History Prior to the Fatality

## Child Information

**Did the child have a history of alleged child abuse/maltreatment?** No
**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

## 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 neither 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) |
|---|---|---|---|---|---|
| 12/20/2019 | Other Child - Other Child, Male, 15 Years | Mother, Female, 37 Years | Inadequate Guardianship | Unsubstantiated | Yes |
| | Other Child - Other Child, Male, 15 Years | Father, Male, 42 Years | Inadequate Guardianship | Unsubstantiated | |
| | Other Child - Other Child, Male, 15 Years | Father, Male, 42 Years | Lacerations / Bruises / Welts | Unsubstantiated | |

**Report Summary:**
An SCR report alleged a 15yo other child (OC) resided with the SM and visited his BF's home. The SM kicked the OC out of the home and would not plan for him. The OC stayed with his friends or on the street. On 12/11/19, the OC went to the SM's home, and he was under the influence of an unknown drug. The OC was in an altercation with the SF. The SF grabbed the OC by his neck and punched him. The OC sustained scratches on his neck. The OC became angry and punched a window. A subsequent report was received on 1/20/20 alleging the SM and SF were unable to control the OC's behaviors. The OC was detained by LE. Attempts were made to contact the SM and SF to no avail. The OC required shelter.

**Report Determination:** Unfounded | **Date of Determination:** 02/03/2020

**Basis for Determination:**
The allegations were unsubstantiated. The OC reported he became angry when the mother would not let him into the home and that he broke a window to enter the home. The OC denied the SF harmed him. The OC stated that sometimes he was defiant. The mother denied kicking the OC out of the home, rather he was supposed to be at his father's home for visitation.

**OCFS Review Results:**
The investigation was initiated timely. The sources of the reports were contacted. The 7-day Safety Assessment was completed timely. Written Notice of Existence was not provided to the adult sibling. A CPS history check was completed untimely. The record did not reflect interviews with the SF or siblings were thorough.

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

**Issue:**
Review of CPS History
**Summary:**
A CPS history check was documented untimely on 12/27/19.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(i)
**Action:**
Within 1 business day of a report, WCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, WCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

**Issue:**
Failure to Conduct a Face-to-Face Interview (Subject/Family)
**Summary:**
The record did not reflect attempts to contact the SF regarding the SCR reports; he was a subject of the reports. The record did not reflect the adult sibling was attempted to be interviewed. Although the then 7-year-old sibling was seen, the record did not reflect he was interviewed regarding overall safety and risk, nor was he interviewed about the allegations.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(a)
**Action:**
WCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

**Issue:**
Failure to provide notice of report
**Summary:**
Although written notice of the SCR report was provided timely to the mother, father of the then 15-year-old OC and SF the record did not reflect the adult sibling, who resided in the home, was provided with written notice.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
WCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

[redacted]

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

1/4/06- 2/27/06 The SM was substantiated for IG of 2 children.

1/5/06- 2/27/06 The SM was substantiated for IG of 2 children.

1/30/06- 3/30/06 The SM was substantiated for IG of 2 children.

10/17/12- 12/10/12 The SM and SF were unsubstantiated for IG, L/B/W and XCP of 2 children.

10/8/15- 12/7/15 The SM was substantiated for IG of a child. The SM and SF were substantiated for LS of 2 children. The SF was unsubstantiated for the IG of a child.

3/16/17- The SM and SF were unsubstantiated for IG and LS of a child.

6/3/17- 7/28/17 The SM and SF were unsubstantiated for XCP, IG and IF/C/S of a child.

10/18/17- 11/14/17- The SM was unsubstantiated for IG, LMC and LS of a child.

## Known CPS History Outside of NYS

There was 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