Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-23-022

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

Issue Date: Aug 16, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 04/25/2023
Initial Date OCFS Notified: 04/25/2023

Presenting Information

Two SCR reports were received on 4/25/23 and alleged the paternal grandmother and her boyfriend were co-sleeping with the 2-year-old subject child. The child was last seen alive and well around 5:00AM and sometime before 8:00AM, the boyfriend woke up and found the child cold, motionless, and she had blood coming from her mouth and nose. In addition, the child had a swollen tongue and presented with an unexplained quarter size bruise on her left cheek. The boyfriend contacted 911, EMS arrived, and the child was in cardiac arrest. The child was transported to the hospital where she was then pronounced dead. The subject child was an otherwise healthy child, the paternal grandmother, and her boyfriend provided no explanation for her death.

Executive Summary

On 4/25/23 the Onondaga County Department of Children and Family Services (OCDCFS) received two SCR reports regarding the death of the 2-year-old female child. The initial report contained allegations of DOA/Fatality and Inadequate Guardianship against the paternal grandmother and her boyfriend (OA). The subsequent report contained allegations of DOA/Fatality, Inadequate Guardianship, Lacerations/Bruises/Welts, and Swelling/ Dislocations/ Sprains against the subject mother, subject father, paternal grandmother, and her boyfriend. The child resided with her mother but at the time of the fatality, was being cared for by her paternal grandmother and her boyfriend for four days prior to the incident. The subject father also resided with the paternal grandmother, but he and the subject mother had no contact with the child since 4/21/23. OCDCFS immediately initiated their investigation with law enforcement; however, were unaware there was a 6-year-old surviving half-sibling until 57 days into their investigation. Once information was obtained about the sibling, OCDCFS immediately assessed the child to be safe in his mother's care and recommended the father be supervised while executing his parenting time.

Through a joint investigation with law enforcement, it was learned on 4/24/23, the day prior to the fatality, the child went to bed around 6:30PM, and co-slept in the bed with her paternal grandmother and her boyfriend. The child was observed to rouse throughout the night and in the early morning on 4/25/23. The child did not get out of the bed. Around 7:00AM, the boyfriend moved the subject child to the subject father's bedroom. When he went to put her down on the bed, he noticed the child was limp and observed blood on her cheek. The boyfriend and paternal grandmother then contacted emergency medical services and began CPR. Emergency medical services and law enforcement responded to the home and began life-saving measures. The child was in cardiac arrest and transported to the hospital where she was intubated and later pronounced dead.

OCDCFS communicated with law enforcement and learned the criminal investigation was still open, and no criminal charges were pending at the time this report was written. Contact with the medical examiner's office revealed on 4/26/23, a preliminary forensic examination was completed. The external examination showed the child had minor facial abrasions and bruising to her back. The internal examination showed no significant injuries. There was no evidence of congenital abnormalities, infection, or disease. Per law enforcement, toxicology results were received and showed positive results for high levels of fentanyl. At the time this report was written, the official manner and cause of death were still pending. In addition, the CPS investigation remained open and not yet determined.

OCDCFS communicated with collateral contacts such as the child's pediatrician, hospital staff and community-based services. OCDCFS discussed bereavement services and burial assistance with the mother and father. In addition, OCDCFS referred the mother to mental health and case management services.

PIP Requirement
OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDCFS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDCFS 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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Was the decision to close the case appropriate? Unknown
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:
At the time this report was written, the investigation was still open and not yet determined.

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: 04/25/2023 **Time of Death:** 08:35 AM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 07:59 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Yes

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	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	25 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	44 Year(s)
Other Household 1	Other Adult - Grandmothers' boyfriend	Alleged Perpetrator	Male	50 Year(s)

LDSS Response

Upon receipt of the SCR reports on 4/25/23, OCDCFS initiated their investigation within 24 hours, coordinated their efforts with law enforcement, spoke to the source of the reports, and corresponded with the District Attorney and Medical Examiner regarding the fatality.

OCDCFS and law enforcement conducted a visit to the residence, the home was observed and met minimal standards. The caseworker noted there were empty cans of Labatt Ice and Keystone Lights in the kitchen and living room as well as loose tobacco on the dining room table. The subject father’s bedroom was observed, the bed sheet had a brown circular stain, and the blanket had a brown smeared stain. In addition, there was a small amount of dark liquid on the floor, that the caseworker noted was about three inches in diameter and appeared to be separating. When asked by law enforcement to clarify what the stains were, the OA explained the stain on the sheet was the SC's blood, the smear on the blanket was food and the liquid on the floor came from the SC.

OCDCFS, law enforcement and the medical examiner all conducted interviews with the OA on 4/25/23. The OA explained on 4/24/23, the SC was playing outside when the family dog knocked her over causing her to fall on landscaping bricks, injuring her back. The child’s back was examined by the OA but there were no noticeable injuries observed. The child continued to play and then subsequently fell off her scooter, injuring her nose. Around 6:30PM, the OA put the SC to bed in the bedroom he shares with the PGM. The OA and PGM co-slept with the child. The child was observed to rouse throughout the night at 10:00PM and between 2-3:00AM on 4/25/23. Around 7:00AM, the OA moved the child to the subject father's bedroom and noticed the child was limp and observed blood on her cheek. The OA called for the PGM, she started CPR on the bedroom floor, then moved the SC to the dining room table where she continued CPR while the OA contacted 911.

OCDCFS and law enforcement spoke with the PGM at the hospital on 4/25/23. The PGM explained on 4/24/23 she arrived home from work and began arguing with the OA because the home was not clean. The OA told her to quiet down and informed her the SC was sleeping. She then went and looked in her bedroom and observed the SC sleeping. The PGM explained the OA was in and out of the home all night, she went to bed around 5:00AM with the SC in the bed and

indicated the child was fine. The PGM stated later the OA woke her up informing her of the SC's state and she thought he was kidding. During the PGM's interview, casework staff noted her head was "lolled to the side," she appeared very weak, spoke quietly, and kept her eyes closed.

OCDCFS spoke with law enforcement and learned video footage was obtained that contradicts the OA's recollection of events. After reviewing video footage, law enforcement did not observe the child outside playing the day prior to the fatality; however, they did observe the OA leave the residence without the child for approximately 25 minutes. Law enforcement attempted to speak with the OA and PGM after receiving the preliminary autopsy report; however, they refused to cooperate.

OCDCFS and law enforcement, completed interviews with the mother and father, both interviews were conducted at the hospital and were brief. At the request of law enforcement, OCDCFS had not yet addressed the toxicology results and video footage due to their open criminal investigation. At the time this report was written, it remained unclear how the child gained access to the fentanyl.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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? Yes
Comments: Onondaga County referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063568 - Deceased Child, Female, 2 Yrs	063569 - Grandparent, Female, 44 Year(s)	DOA / Fatality	Pending
063568 - Deceased Child, Female, 2 Yrs	063573 - Other Adult - Grandmothers' boyfriend, Male, 50 Year(s)	Internal Injuries	Pending
063568 - Deceased Child, Female, 2 Yrs	063573 - Other Adult - Grandmothers' boyfriend, Male, 50 Year(s)	Inadequate Guardianship	Pending
063568 - Deceased Child, Female, 2 Yrs	063573 - Other Adult - Grandmothers' boyfriend, Male, 50 Year(s)	DOA / Fatality	Pending
063568 - Deceased Child, Female, 2 Yrs	063571 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Pending
063568 - Deceased Child, Female, 2 Yrs	063571 - Mother, Female, 21 Year(s)	DOA / Fatality	Pending
063568 - Deceased Child, Female, 2 Yrs	063571 - Mother, Female, 21 Year(s)	Swelling / Dislocations / Sprains	Pending
063568 - Deceased Child, Female, 2 Yrs	063725 - Father, Male, 25 Year(s)	Swelling / Dislocations / Sprains	Pending

063568 - Deceased Child, Female, 2 Yrs	063725 - Father, Male, 25 Year(s)	Lacerations / Bruises / Welts	Pending
063568 - Deceased Child, Female, 2 Yrs	063571 - Mother, Female, 21 Year(s)	Internal Injuries	Pending
063568 - Deceased Child, Female, 2 Yrs	063725 - Father, Male, 25 Year(s)	Internal Injuries	Pending
063568 - Deceased Child, Female, 2 Yrs	063571 - Mother, Female, 21 Year(s)	Lacerations / Bruises / Welts	Pending
063568 - Deceased Child, Female, 2 Yrs	063725 - Father, Male, 25 Year(s)	Inadequate Guardianship	Pending
063568 - Deceased Child, Female, 2 Yrs	063725 - Father, Male, 25 Year(s)	DOA / Fatality	Pending
063568 - Deceased Child, Female, 2 Yrs	063569 - Grandparent, Female, 44 Year(s)	Swelling / Dislocations / Sprains	Pending
063568 - Deceased Child, Female, 2 Yrs	063569 - Grandparent, Female, 44 Year(s)	Lacerations / Bruises / Welts	Pending
063568 - Deceased Child, Female, 2 Yrs	063569 - Grandparent, Female, 44 Year(s)	Internal Injuries	Pending
063568 - Deceased Child, Female, 2 Yrs	063569 - Grandparent, Female, 44 Year(s)	Inadequate Guardianship	Pending
063568 - Deceased Child, Female, 2 Yrs	063573 - Other Adult - Grandmothers' boyfriend, Male, 50 Year(s)	Lacerations / Bruises / Welts	Pending
063568 - Deceased Child, Female, 2 Yrs	063573 - Other Adult - Grandmothers' boyfriend, Male, 50 Year(s)	Swelling / Dislocations / Sprains	Pending

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?	☐	☐	☒	☐
Explain: OCDCFS was unaware there was a surviving half-sibling until 57 days into their investigation. Once information was obtained about the sibling, OCDCFS immediately assessed the child to be safe in his mother's care.				

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: The mother and father were provided information for bereavement services and the mother was referred for mental health and case management services.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine

Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
OCDCFS was unaware there was a surviving half-sibling until 57 days into their investigation. Once information was obtained about the sibling, OCDCFS immediately assessed the child to be safe in his mother's care. OCDCFS recommended that the father be supervised while executing his parenting time.

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Case management services

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? No
Explain:
OCDCFS learned on 6/21/23, 57 days into their investigation that there was an 6-year-old surviving half-sibling. The record did not reflect any services being offered to the surviving half-sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services and burial assistance was discussed with the mother and father. The mother was also referred to mental health and case management 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)
06/27/2022	Other Child - unrelated child, Male, 2 Years	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
An SCR report was received and alleged the SF broke into his girlfriends (OA2) home and physically assaulted her in the presence of the OC. The SF had a history of physically assaulting the OA2.

Report Determination: Indicated | **Date of Determination:** 07/28/2022

Basis for Determination:
The SF showed up unannounced to the OA2's home and broke through the door to the residence. He then proceeded to physically assault the OA2 in front of the OC. There was a stay away OP in place issued prior to the incident that the SF and OA2 were unaware was still active. A warrant was issued for the SF's arrest, he was charged with Endangering the Welfare of a Child, Criminal Mischief 4th, Burglary 2nd, Harassment 2nd, and Criminal Contempt 1st. The SF admitted he assaulted the OA2 in front of the OC.

OCFS Review Results:
The record reflected OCDCFS initiated their investigation and reviewed history within 24 hours and spoke to the source. The determination was completed timely and accurately. The risk assessment was reflective of case circumstances. The NOE was sent to all adults, however; the notice of Indication was not sent to any adults listed on the case.

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

Issue:
Failure to Provide Notice of Indication
Summary:
All the adults listed on the case were not provided a Notice of Indication.
Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

Action:

If the local district determines a report assigned to the investigative track is "indicated" it must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification within seven days of the determination in such for as required by OCFS.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/02/2022	Deceased Child, Female, 1 Years	Father, Male, 23 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:

An SCR report was received and alleged the SF physically assaulted the SM twice while the subject child was present. The SF kicked in the mother's door to her residence, kicked the SM on her head multiple times and choked her. The SF then fled the home.

Report Determination: Indicated

Date of Determination: 03/28/2022

Basis for Determination:

The SM reported to casework staff and law enforcement on 2/1/22 the SF physically assaulted her on two separate occasions. During the altercations, the subject child was present in the home and the mother sustained injuries requiring medical attention. A warrant was issued for the SF arrest, he was charged with burglary, assault, and criminal obstruction of breathing. The case was indicated against the SF for Inadequate Guardianship. Domestic violence services were discussed with the mother.

OCFS Review Results:

The recorded reflected OCDCFS initiated their investigation and reviewed history within 24 hours and spoke to the source. The determination was completed timely and accurately. The 7-day Safety Assessment was not completed timely, it was 35 days overdue when it was approved. Although OCDCFS sent the required NOE to the SF this was not until 3/21/22, 40 days after the case initiation. Another letter was sent on that same date requesting immediate contact. The case was then closed 7 days later. There were no attempts to promptly engage the subject of the report.

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

Issue:

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:

Diligent efforts were not reflected in the case record to locate and interview the SF, despite that he was a subject of the report and the allegations against him were indicated. The SF was not notified of the report until 40 days after the case initiation date on 2/2/2022.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The 7-day Safety Assessment was not completed timely; it was submitted and approved 35 days after the initial due date on 2/9/2022.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:
Within seven days of receipt of the report, OCDCFS will complete a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm. The results of each safety assessment must be documented in the case record in the form and manner required by OCFS.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/20/2021	Deceased Child, Female, 1 Days	Mother, Female, 18 Years	Inadequate Guardianship	Far-Closed	No
	Deceased Child, Female, 1 Days	Mother, Female, 18 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
An SCR report was received on 1/20/21 and alleged the mother gave birth to a baby girl on 1/19/21. At the time of delivery, the mother and child tested positive for marijuana and the mother admitted to using marijuana throughout her pregnancy.

OCFS Review Results:
The record reflected OCDCFS initiated their investigation within 24 hours, spoke to the source of the report and completed a CPS history check timely. Supportive services such as mental health referral was offered to the SM; however, she declined. Progress notes and assessments were completed within the required time frames. The SM and casework staff discussed the initial options for the case track as well as case closing.

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 NYS.

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