# Child Fatality Report

## Report Identification Number: SY-23-037

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

**Issue Date: Feb 12, 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 | | |

## Case Information

**Report Type:** Child Deceased **Jurisdiction:** Tompkins **Date of Death:** 08/28/2023
**Age:** 5 month(s) **Gender:** Male **Initial Date OCFS Notified:** 08/28/2023

### Presenting Information

An SCR report was received on 8/28/23 alleging that on 8/27/23, the mother fell asleep with the subject child in her bed. At 3:35AM, the mother woke and found the subject child unresponsive. The mother began CPR and called 911, EMS arrived within 4 minutes and continued CPR. The subject child was transported to the hospital where CPR was continued for another 30 minutes before the subject child was pronounced deceased. It was suspected that the unsafe sleep practices contributed to the death of the subject child.

### Executive Summary

On 8/28/23, Tompkins County Department of Social Services (TCDSS) received an SCR report regarding the death of the 5-month-old male child. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the subject mother. At the time of his death, the subject child resided with the subject mother, the father and the 2-year-old surviving sibling. TCDSS immediately assessed the safety of the surviving sibling and determined he was safe in the care of his subject mother and father.

Through a joint investigation with law enforcement, it was learned that on 8/27/23, the subject child was in the care of his mother. At 9:45PM, the mother fed the subject child and then she, the subject child and 2-year-old surviving sibling all co-slept in the parents' bed. The mother woke and found the subject child unresponsive. She immediately called 911 and performed CPR, within 4 minutes EMS arrived and continued lifesaving efforts. The subject child was transported to the hospital where he was pronounced deceased at 4:45AM on 8/28/23.

TCDSS spoke with an investigator for the medical examiner on 8/28/23 and learned that when the subject child arrived at the hospital, there were no signs of rigor mortis or lividity. It did not appear that the subject child had been deceased for long. The subject child's temperature was 91.3 upon arrival, about an hour after 911 was called.

TCDSS spoke with law enforcement and learned there were no marks or injuries to the subject child that indicated any signs of trauma. The subject child had a clean diaper and there was nothing concerning observed. Multiple attempts were made to request the final autopsy report from the medical examiner's office; however, the final autopsy report had not been received at the time this report was written. The criminal investigation appeared to be ongoing, awaiting the results of the final autopsy report.

The record reflected the 30-Day Safety Assessment and Risk Assessment Profile were not completed timely. In addition, progress notes were entered over 30-days after their corresponding event date. At the time this report was written the investigation remained open due to pending autopsy results and had not yet been determined.

TCDSS provided the family with information for several mental health treatment providers including resources specifically for bereavement services. TCDSS coordinated with temporary assistance and requested burial assistance which the family accepted. TCDSS gathered pertinent information from collaterals such as the children's pediatricians, EMS, probation, and the maternal grandmother.

**PIP Requirement**

TCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the TCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented,

TCDSS 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?** N/A
- **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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

**Explain:**
At the time this report was written, the case remained opened and not yet determined.

**Was the decision to close the case appropriate?** N/A

**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:**
Caseworker activity was not commensurate with case circumstances as the 30-day safety assessment was not completed and progress notes were entered over 30-days after their corresponding event date.

### Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Timely/Adequate 30-Day Safety Assessment |
| **Summary:** | At the time this report was written, the 30-day safety assessment was 111 days overdue and had not yet been completed in Connections. |
| **Legal Reference:** | CPS Program Manual, Chapter 6, K-2 |
| **Action:** | The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 30-day safety assessment in Connections. |
| | |
| **Issue:** | Adequacy of Progress Notes |
| **Summary:** | 25 progress notes were entered over 30-days after their corresponding event date. |

| Legal Reference: | 18 NYCRR 428.5 |
|---|---|
| Action: | Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded. |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 08/28/2023 **Time of Death:** 04:45 AM

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

**County where fatality incident occurred:** Tompkins
**Was 911 or local emergency number called?** Yes
**Time of Call:** 03:35 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 | Male | 5 Month(s) |
| Deceased Child's Household | Father | No Role | Male | 27 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 20 Year(s) |
| Deceased Child's Household | Sibling | No Role | Male | 2 Year(s) |

### LDSS Response

Upon receipt of the SCR report, TCDSS initiated their investigation within 24 hours, contacted the source of the report, reviewed prior CPS history, and coordinated their efforts with law enforcement and the medical examiner. In addition, the district attorney's office was notified of the fatality. TCDSS immediately assessed the surviving sibling to be safe in the home and in the care of his parents.

TCDSS spoke with law enforcement and learned interviews would be conducted at their precinct. Law enforcement

interviewed the father while CPS observed, and CPS and law enforcement interviewed the subject mother together. During their interviews, the parents reported on 8/27/23, the family had a normal day. In the afternoon they went to the park and when they arrived home the father cooked dinner and they ate. Around 9:45 PM, the father left for work and the subject mother fed the subject child while sitting on her bed. The subject child fell asleep, and the mother laid him down in the parent's bed next to her, on his back, propped on a pillow. The subject child was wearing a diaper and the mother denied having a blanket over him, but acknowledged there was a blanket of the bed. The subject child slept between the subject mother and the 2-year-old sibling on the parents' queen size bed.

The subject mother went to sleep around 10:30PM; when she woke around 3:30AM, she found the subject child by her thigh. The subject mother was unsure if the child was on his back or his stomach. She picked him up and described that the child was "floppy". She shook him in an attempt to wake him but was unsuccessful. She then watched his chest and realized he wasn't breathing. The subject mother immediately called 911 and performed CPR; EMS arrived four minutes later. The father was at work during this incident and received a call from the subject mother at 3:59AM, informing him of the situation. The father left work and ran home, he made it home while EMS was still performing life-saving efforts. The subject child was transported to the hospital where he was pronounced deceased at 4:45AM.

TCDSS discussed substance and alcohol use with the mother. The SM confirmed she smoked marijuana on 8/27/23, during the day, around 12:00PM. She denied being under the influence at the time of the incident and denied consuming any alcohol.

The subject mother and father both confirmed the subject child would sometimes co-sleep in bed with the parents. There was a Pack 'N Play in the parents' bedroom that the subject child would also sleep in.

TCDSS communicated with the children's pediatricians and learned the subject child was seen regularly for well child visits. He appeared healthy and well-nourished at every appointment and there were no concerns noted for his health. At the subject child's last appointment on 6/15/23, he was diagnosed with a viral infection. The 2-year-old sibling was last seen on 5/9/23 and there were no concerns for his physical health.

## Official Manner and Cause of Death

**Official Manner:** Unknown
**Primary Cause of Death:** Unknown
**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:** Tompkins County does not have an OCFS approved Child Fatality Review Team.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 066224 - Deceased Child, Male, 5 Month(s) | 066226 - Mother, Female, 20 Year(s) | DOA / Fatality | Pending |
| 066224 - Deceased Child, Male, 5 Month(s) | 066226 - Mother, Female, 20 Year(s) | Inadequate Guardianship | 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:**
There was no 30-day safety assessment completed in Connections.

## 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 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** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes

**Explain:**

TCDSS provided the family with information for several mental health treatment providers including resources specifically for bereavement services. TCDSS coordinated with temporary assistance and requested burial assistance which the family accepted.

## 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?** No

### Infants Under One Year Old

**During pregnancy, mother:**

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

**Infant was born:**

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

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 04/01/2023 | Sibling, Male, 2 Years | Mother, Female, 20 Years | Lack of Supervision | Far-Closed | Yes |
| **Report Summary:** | | | | | |

The SCR report alleged for over an hour, the mother was not providing an adequate level of supervision to the 1yo SS. The mother failed to provide the SS with adequate supervision. The SS was in the elevator of an apartment building alone wearing only a diaper and shirt.

**OCFS Review Results:**
TCDSS immediately initiated their investigation, coordinated with law enforcement, spoke with the source and completed a CPS history review. TCDSS interviewed both parents, observed the children and the home. The FLAG was completed; however, it was completed one month late and did not reflect the concerns for supervision. The 7-day safety assessment was completed with no safety concerns. Appropriate collateral contacts were made with the children's medical providers and TCDSS entered progress notes contemporaneously. TCDSS did not provide the family with safe sleep education or documentation.

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

**Issue:**
Failure to provide safe sleep education/information

**Summary:**
TCDSS observed the 3-week-old SC asleep on an adult bed with a boppy pillow; however, the record did not reflect safe sleep information and education were provided to the parents.

**Legal Reference:**
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

**Action:**
TCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

**Issue:**
FAR-Timely/Adequate Family-Led Assessment Guide

**Summary:**
The family-led assessment guide was completed 30 days late and did not accurately reflect the concerns for supervision.

**Legal Reference:**
18 NYCRR 432.13 (e)(2)(iii)-(v)

**Action:**
The family-led assessment guide should be initiated as soon as possible after receipt of the child protective service report, but no more than 30 days following receipt of the report.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 06/20/2021 | Sibling, Male, 1 Months | Mother, Female, 18 Years | Inadequate Guardianship | Substantiated | Yes |
| | Sibling, Male, 1 Months | Mother, Female, 18 Years | Parents Drug / Alcohol Misuse | Substantiated | |
| | Sibling, Male, 1 Months | Father, Male, 25 Years | Inadequate Guardianship | Substantiated | |
| | Sibling, Male, 1 Months | Father, Male, 25 Years | Parents Drug / Alcohol Misuse | Substantiated | |

**Report Summary:**
The SCR report alleged that on 6/19/21, into the early morning of 6/20/21, the mother and father abused alcohol to the point of impairment while acting as the sole caregivers to their six-week-old child. The parents were abusing alcohol simultaneously while the father was driving the vehicle with the child in the car. While the parents were impaired, the father was driving with the mother and surviving sibling in the car and crashed into a tree. The mother was aware and failed to adequately address the situation. The mother and father were residing with the MGM and 14yo maternal uncle.

**Report Determination:** Indicated | **Date of Determination:** 09/23/2021

**Basis for Determination:**
Both parents consumed alcohol while in the car with the SS present. The SF crashed the car into a tree. His BAC was .15 and he was charged with a felony for Driving While Intoxicated. The father also had a previous DWI charge from December of 2020. The SM was also drinking and aware that the father was drinking, and she failed to intervene. A safety plan was put in place and the parents were not able to be unsupervised with the SS. The SM completed a substance abuse evaluation and was recommended for educational sessions. At case closure the SF was still required to be supervised with the SS. The SF completed an evaluation and was recommended for treatment but was not attending his sessions.

**OCFS Review Results:**
TCDSS initiated their investigation within 24 hours, contacted the source and completed a CPS history review. The home was observed, and the children were assessed to be safe. Throughout the case the adults were spoken to with regard to the allegations and concerns; however, the 14yo child was never interviewed. Safety assessments were completed but did not reflect the concerns noted in the case record. The case was closed a month overdue, and with a safety plan still in place and with no resolution or legal consult.

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

**Issue:**
Assessment as to need for Family Court Action

**Summary:**
A safety plan was implemented due to the serious nature of the circumstances that lead to CPS involvement. The case was closed with the safety plan still in place and without the SF fully engaged in treatment. The record did not reflect a legal consultation was completed.

**Legal Reference:**
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

**Action:**
TCDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

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

**Summary:**
During the course of the investigation information was obtained that the 14yo child was drinking alcohol and the address where he and the subject parents resided, was a "party house". The 14yo child was never interviewed regarding the initial concerns of the case or the newly identified information.

**Legal Reference:**
18 NYCRR 432.1 (o)

**Action:**
TCDSS will incorporate key safety-related questions as they pertain to case circumstances. / The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

**Issue:**
Adequacy of Documentation of Safety Assessments

**Summary:**
The 7-day safety assessment and the investigation determination safety's decisions did not reflect what was in the record. A safety plan was made with both parents to have no unsupervised contact with the 3-week-old SS. Neither safety assessment reflected the safety plan, and at the time of case closure, the SF's safety plan was still in place.

**Legal Reference:**
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

**Action:**

The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

**Issue:**
Pre-Determination/Home Visit

**Summary:**
Although TCDSS evaluated the home where the family was originally staying, the record reflected the SM and SS were staying at her friend's house because she didn't want the child around the 14yo maternal uncle. There were no attempts to observe the new environment where the family was residing.

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

**Action:**
Prior to a determination being made, the investigation must include one home visit so as to evaluate the environment of the child named in the report as well as other children in the same home.

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

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

## Known CPS History Outside of NYS

There was no know 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