Child Fatality Report

Report Identification Number: AL-20-029

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

Issue Date: Feb 25, 2021

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		
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	
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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Albany
Gender: Male
Date of Death: 09/12/2020
Initial Date OCFS Notified: 09/12/2020

Presenting Information

An SCR report was received with concerns that on 9/11/20, the mother and father went to sleep with the 2-month-old subject child in bed with them, and on 9/12/20, awoke to find the child under a comforter and unresponsive. The father called 911, but it was unknown if he called immediately or if there was a delay. Emergency services transported the child to the hospital, and he was pronounced dead. The unsafe sleeping arrangement contributed to the child's death.

Executive Summary

This fatality report concerns the death of a two-month-old male subject child that occurred on 9/12/20. A report was made to the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother and father. Albany County Department for Children, Youth and Families (ACDCYF) received the report and completed a thorough investigation into the child's death. An autopsy was completed, and the official cause of death was noted as asphyxiation and the manner was accident. The medical examiner noted the asphyxiation occurred while the child was in an unsafe sleeping environment.

At the time of the child's death, he resided with his mother, father, twin sister, and three surviving siblings, ages 16, 15, and 12 years old. The investigation revealed that the mother had placed the twins in a king-sized bed on the night of 9/11/20 and fell asleep beside them. The father arrived home from work at 1:00AM on 9/12/20 and got into the bed; the twins were in the middle and sleeping on their stomachs. The parents awoke around 7:30AM and did not see the subject child. The mother pulled down the comforter and found the child face down on the mattress, blue and unresponsive. The father immediately contacted emergency services while the mother began life saving measures. The ambulance arrived and transported the child to a nearby hospital, where he was pronounced deceased at 8:21AM.

From the time the investigation began to the time of its closure, ACDCYF interviewed family members and spoke with collateral sources. ACDCYF offered the family services to address their grief. ACDCYF determined the parents placed the child at imminent risk of harm by placing him in an unsafe sleeping environment. ACDCYF indicated and closed the investigation.

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

Explain:
ACDCYF gathered information to determine the allegations and assess the safety of the SS.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/12/2020 **Time of Death:** 08:21 AM

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

County where fatality incident occurred: Albany
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 6 Hours
At time of incident supervisor was: Not impaired.

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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	45 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Sibling	No Role	Male	16 Year(s)
Deceased Child's Household	Sibling	No Role	Female	15 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)

LDSS Response

On 9/12/20, ACDCYF received the fatality report regarding the death of SC, which occurred on that same date. ACDCYF initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. ACDCYF learned there were 4 SS and worked promptly to assess their safety.

On the date the report was received, ACDCYF completed a home visit and interviewed family members. SM was spoken with first and explained nothing out of the ordinary occurred in the hours leading up to the fatal incident. She reported she and the twins were asleep in her and SF's bed, and SF was at work. She stated he arrived home around 1:00AM and got into the bed with them and fell asleep. SM was on the outside, facing the wall, with SC in her arms, while SF was on the opposite side with his back to the wall, facing the twin. There were pillows and a thick comforter on the bed. SM reported she and SF awoke around 7:30AM that morning, and the twin was beside her, but SC was not. SM said she asked SF where SC was, pulled the comforter down and found SC face down on the mattress. She explained she rolled SC onto his back and saw that he was blue and not breathing; SF immediately called 911. SF was also interviewed and provided the same account of events. ACDCYF observed a portable crib beside the bed. The parents explained the twins slept in the crib as well as in the bed and stated they had been educated surrounding safe sleep practices. There were no safety concerns noted regarding the home environment.

On 9/12/20, ACDCYF interviewed the 2 oldest SS. The SS did not disclose any safety concerns and denied having any information surrounding SC's death as they were both asleep. Both CHN stated there was nothing out of the ordinary the previous day and SC seemed fine. On this same date, ACDCYF met with the 12yo SS and his father at the LDSS office. The 12yo was at his father's house when the incident took place and had no information surrounding such. He did not disclose anything of concern regarding his care or the care of his siblings.

Throughout the investigation, ACDCYF spoke with several collateral sources, including the CHN's pediatrician, hospital

staff, first responders, the ME and LE. LE found no criminality on behalf of either parent. Services were offered to the family in response to SC's death. ACDCYF found evidence that the parents placing SC in an unsafe sleeping environment contributed to his death, and therefore indicated the report.

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
Comments: This fatality investigation was conducted by the Albany County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was reviewed by the Albany County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056241 - Deceased Child, Male, 2 Mons	056242 - Mother, Female, 38 Year(s)	DOA / Fatality	Substantiated
056241 - Deceased Child, Male, 2 Mons	056242 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
056241 - Deceased Child, Male, 2 Mons	056243 - Father, Male, 45 Year(s)	DOA / Fatality	Substantiated
056241 - Deceased Child, Male, 2 Mons	056243 - Father, Male, 45 Year(s)	Inadequate Guardianship	Substantiated
056244 - Sibling, Female, 2 Month(s)	056242 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
056244 - Sibling, Female, 2 Month(s)	056243 - Father, Male, 45 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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACDCYF provided the parents with bereavement counseling referrals and information on counseling programs for the SS. ACDCYF also provided the parents with information on assistance with funeral costs.

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:
ACDCYF provided the parents with information surrounding grief services for the SS, as well as a support program through their school district.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACDCYF provided the parents with referrals for grief and bereavement services.

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
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:
- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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)
05/06/2019	Sibling, Female, 14 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 11 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Female, 14 Years	Mother, Female, 36 Years	Swelling / Dislocations / Sprains	Unsubstantiated
Sibling, Male, 11 Years	Mother, Female, 36 Years	Lacerations / Bruises / Welts	Unsubstantiated

Report Summary:
This SCR report was received on 5/6/19 which alleged the mother was physically abusive toward the CHN, and caused bruising to the now 12 and 15-year-old SS. This report was received while the investigation from May 2018 was still open but could not be consolidated due to the amount of time that passed.

Report Determination: Unfounded | **Date of Determination:** 09/16/2020

Basis for Determination:
ACDCYF interviewed family members, including all 3 SS, regarding the allegations. The older SS denied any physical discipline in the home. The now 12yo SS reported SM punched him twice on his thigh. A large bruise was observed by ACDCYF. The now 16yo SS told ACDCYF he caused the bruise when he and the 12yo were playing a video game. None of the CHN expressed fear of SM or BF. Collateral sources were spoken with and no concerns were expressed. SC died while this investigation was still open.

OCFS Review Results:
This investigation was open from May 2019 until September 2020. There were no casework contacts from 5/21/20 until after SC died on 9/12/20. Most progress notes were entered more than one month after event dates. The final safety assessment does not speak to the safety of the SS, only the circumstances surrounding the fatality, which was a separate report. The record did not reflect the BF of the now 15yo SS was contacted or notified of the report. The record did not reflect any services were offered to the family prior to the death of SC.

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:
There were no casework contacts from 5/21/20 until after SC died on 9/12/20. The record did not reflect the BF of the now 15yo SS was contacted.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
The Albany Regional Office advised there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Most progress notes were entered more than one month after event dates.
Legal Reference:
18 NYCRR 428.5
Action:
The Albany Regional Office advised there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
The final safety assessment did not speak to the safety of the SS, only the circumstances surrounding the fatality, which was a separate report.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
The Albany Regional Office advised there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Failure to offer services
Summary:
SM had a recent history of interpersonal violence in relationships. The record did not reflect any services were offered to address this concern.
Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
ACDCYF will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Failure to provide notice of report
Summary:
The record did not reflect the BF of the now 15yo SS was notified of the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
The Albany Regional Office advised there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/27/2018	Sibling, Male, 10 Years	Other Adult - 12yo SS BF, Male, 42 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 10 Years	Other Adult - 12yo SS BF, Male, 42 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
This SCR report was received with concerns the biological father of the now 12yo SS was driving while intoxicated with the child in the car. The report alleged the father was speeding, had no taillights or working headlights. The report stated when the police pulled him over, the father resisted arrest.

Report Determination: Indicated | **Date of Determination:** 10/28/2019

Basis for Determination:
ACDCYF conducted interviews with family members and collateral sources. The parents were involved in an ongoing custody battle. The now 12yo CH was interviewed and did not note any concerns regarding his parents drinking alcohol. BF was arrested and charged with DWAI. ACDCYF contacted LE, the CHNs pediatrician and schools.

OCFS Review Results:
There was no casework activity from 6/9/18 to 9/9/18, and again from 10/21/18 to 5/7/19, after the subsequent SCR report was received. Most progress notes were entered one year or more after event dates. The final safety assessment does not speak to the safety of the SS, only the circumstances surrounding the fatality, which was a separate report. Only the 12yo CH was interviewed regarding the initial report; the other CHN were not interviewed until after the subsequent

was received. The record did not reflect the BF of the now 15yo SS was contacted or notified of the report. The record did not reflect any services were offered to the family.

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:
There was no casework activity from 6/9/18 to 9/9/18, and again from 10/21/18 to 5/7/19, after a subsequent report was received. The SS were not interviewed regarding the allegations. The record did not reflect the BF of the now 12yo SS was contacted.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
The Albany Regional Office advised there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Most progress notes were entered one year or more after event dates.
Legal Reference:
18 NYCRR 428.5
Action:
The Albany Regional Office advised there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
The final safety assessment does not speak to the safety of the SS, but instead focused on the death of SC and the circumstances surrounding such.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
The Albany Regional Office advised there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Failure to offer services
Summary:
SM had a recent history of interpersonal violence in relationships, including BF. BF had been arrested for driving while intoxicated with SS in the car. The record did not reflect any services were offered to address these concerns.
Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
ACDCYF will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Failure to provide notice of report

Summary:
The record did not reflect the BF of the now 15yo SS was notified of the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
The Albany Regional Office advised there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACDCYF will continue to work on this issue and revise their current PIP if deemed necessary.

[redacted]

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

SM was listed as a subject in three unfounded reports from 2012 to 2017 with common allegations of IG and L/B/W regarding the SS. The BF of the now 12yo SS was listed as a subject in two unfounded reports with common allegations of IG, L/B/W and S/D/S regarding the SS. The BF of the now 16yo SS was listed as a subject in one unfounded report which alleged IG and LS regarding the 16yo SS and an unrelated CH.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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