Child Fatality Report

Report Identification Number: AL-21-030

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

Issue Date: May 09, 2022

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: 1 month(s)
Jurisdiction: Schenectady
Gender: Male
Date of Death: 11/18/2021
Initial Date OCFS Notified: 11/18/2021

Presenting Information

An SCR report was received which alleged the mother fed the one-month-old subject child a bottle at midnight on 11/18/21, and then put the child in his crib. The child was placed on an infant pillow, and there were several blankets in the crib as well. The crib was in the same room as the mother and parent substitute. The parent substitute awoke at an unknown time on 11/18/21 and found the subject child not breathing. The mother and parent substitute brought the child to the hospital, but he could not be revived. Prior to the fatality, he was otherwise healthy. It was unknown if the sleeping conditions contributed to the child's death.

Executive Summary

This fatality report concerns the death of a one-month-old male subject child that occurred on 11/18/21. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother and the parent substitute. Schenectady County Department of Social Services (SCDSS) received the report and investigated the child's death. An autopsy was performed; however, the final autopsy was not received until after the child protective investigation was closed. It noted the immediate cause of death as "asphyxiation from aspiration of gastric content." The child's lungs were observed to have severe pulmonary congestion with edema. SCDSS based their findings on the medical examiner's preliminary cause of death received during their involvement, which was "SIDS due to suffocation."

At the time of the child's death, he resided with his mother and the parent substitute. The subject child's biological father denied paternity and never met the child. The mother had two other children, ages four and five years old, who were in the care and custody of relatives due to the mother's history of substance misuse. The parent substitute also had two other children; however, one had been freed for adoption and he had had no contact with the other child for several years. The investigation revealed that around midnight on 11/18/21, the mother fed the child and then put him to sleep in a bassinet that was beside the mother and parent substitute's bed. The child was propped on an infant pillow with a fleece baby blanket wrapped around it. At around 7:00AM that morning, the parent substitute awoke to find the subject child unresponsive in his bassinet. The parent substitute woke the mother, and then went to get help from his brother, who lived in the upstairs apartment of the same residence. Emergency services were not called, as the mother and parent substitute felt an ambulance would take too long to respond. Instead, the parent substitute's brother drove the mother, parent substitute, and child to the hospital, which was down the street from their home. The mother brought the child into the emergency room, where medical staff attempted life saving measures. The child could not be resuscitated and was pronounced deceased at 8:11AM.

SSCDSS spoke with family members and collateral sources, including law enforcement, the medical examiner, and the pediatrician. It was discovered the subject child had been hospitalized for a respiratory virus from 10/16/21 until 10/19/21 but had been released home to the mother and was reportedly feeling better. There were no concerns noted surrounding the subject child in the days leading up to the fatality, and family members stated the child was acting normally. SCDSS assessed the safety of the mother's two older children and found no safety concerns. Those children remained with their alternative caregivers at the time of this writing. There were no criminal charges brought against the mother or parent substitute regarding the child's death. Services were offered to the family but declined. The mother had been educated surrounding safe sleep practices numerous times since the subject child's birth. SCDSS found some credible evidence that the mother and parent substitute's choice to place the child in an unsafe sleeping environment contributed to his death, and therefore indicated and closed the case.

PIP Requirement
OCFS' review resulted in citations. In response, the cited county will submit a Program Improvement Plan (PIP) to the Regional Office which will identify what action(s) the LDSS has taken, or will take, to address the cited issues. For citations where a PIP is currently implemented, the respective LDSS will review the plan(s) and revise as needed to further 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:
SCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving siblings.

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: 11/18/2021 **Time of Death:** 08:11 AM

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

County where fatality incident occurred: Schenectady
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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? 7 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	24 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	29 Year(s)

LDSS Response

On 11/18/21, SCDSS observed LE interview SM. SM stated she lived with SC and PS. She explained her two other CHN were in the custody of relatives due to SM's past substance misuse concerns. SM reported PS had a child in foster care, and he had no parental rights for that child. SM further explained SC's biological father was "not in the picture" and did not want to be involved in SC's life. LE directed the interview to the events leading up to the fatality. SM explained SC had been diagnosed with a respiratory virus and was hospitalized several weeks ago. She stated as of late he had been eating well and sleeping through the night. SM said on 11/17/21, she noticed SC's breathing was "a little off," but she did not think anything of it. The record did not reflect that this was explored further. SM said she last fed SC around midnight on 11/18/21, and then she propped him on a baby pillow in a bassinet. SM stated the bassinet was attached to the top of a portable crib. She explained she also wrapped a blanket around the baby pillow. SM reported she used the baby pillow, so

SC was elevated when he slept. SM said SC slept in the same room as her and PS, and PS was the first to awake on the morning of 11/18/21. SM said PS woke her up after finding SC not breathing, and then PS went upstairs to get help from his brother. SM stated they felt an ambulance would take too long so they drove SC to the hospital themselves, as the hospital was close to their home. SM said when they arrived, she brought SC right into the emergency room, and the staff took over. SM reported SC was fine the previous day and described him as happy and healthy.

LE then interviewed PS, whose story corroborated what SM had reported. PS stated SC was "acting okay" the day before his death and he had no concerns surrounding SM's care of SC. LE informed SCDSS that PS was a registered sex offender but failed to register at his current address. PS explained he had no restrictions regarding CHN, as his offense was against an adult. PS also stated he was on parole and provided his parole officer's contact information. PS stated he had a child in foster care, but he believed she was adopted. He could not recall her name but stated she was seven years old. He explained he also had an eight-year-old son; however, he did not know where he was and had no recent contact with him.

On 11/18/21, SCDSS spoke with PS's parole officer, who reported no concerns surrounding PS. The officer also stated PS complied with his parole stipulations, and she had no concerns he would harm a CH.

On 11/24/21, SCDSS learned PS had a criminal record from another state involving inflicting serious injuries to his CH, who was one year old at the time. There was further history that PS held a gun to his previous wife and son's heads. An order of protection against PS regarding that CH was active and would remain in place until the CH was 18 years old. Because of these concerns, SCDSS implemented a safety plan where the SSs would have no contact with PS.

By the close of the investigation, SM and PS had ended their relationship. SCDSS received medical records that noted SC had been hospitalized with a respiratory virus from 10/16/21 to 10/19/21 and was discharged home with a medication and instructions to see his pediatrician within 7 days. The record did not reflect if SM gave SC the medication, or the last time he had seen his pediatrician. Collateral sources had no safety concerns surrounding SM's care of SC, and the SSs remained with their alternative caregivers at the time of this writing. SM had been educated surrounding safe sleep practices on more than one occasion. SCDSS gathered some credible evidence that SC's sleeping conditions placed SC at imminent risk of harm and the preliminary cause of death was noted to be "SIDS due to suffocation." Therefore, SCDSS indicated and closed the case.

Official Manner and Cause of Death

Official Manner: Unknown
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 Schenectady County MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: Schenectady 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

060283 - Deceased Child, Male, 1 Mons	060284 - Mother, Female, 24 Year(s)	DOA / Fatality	Substantiated
060283 - Deceased Child, Male, 1 Mons	060284 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
060283 - Deceased Child, Male, 1 Mons	060285 - Mother's Partner, Male, 29 Year(s)	DOA / Fatality	Substantiated
060283 - Deceased Child, Male, 1 Mons	060285 - Mother's Partner, Male, 29 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:

SCDSS spoke with collateral sources and entered notes timely. SC's Dr. was contacted; however, SCDSS did not inquire about his most recent visit, any prescribed medications, or if he attended the follow up appointment per the discharge instructions.

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: The surviving half-siblings remained in the custody of relatives at the close of this investigation.				

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: Although there were two surviving half-siblings, they were in the care and custody of relatives at the time of the fatality, and remained so at the time of this writing.				

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:
SCDSS offered the family services in response to the fatality; however, they were declined. The mother was already engaged in services in her community, and remained so at the close of the case. The record did not reflect if family planning services were discussed.

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:
SCDSS provided the family with service referrals for the surviving half-siblings following the death of the subject child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SCDSS provided service referrals to the parents and caregivers of the subject child following the fatality.

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?	Yes
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)
12/23/2020	Sibling, Female, 3 Years	Other Adult - SS's BF, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 3 Years	Other Adult - SS's BF, Male, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
This SCR report was received by Albany County Department for Children, Youth, and Families (ACDCYF) with concerns when on visitation with SM, the youngest surviving half-sibling sustained bruising to her buttocks and a linear welt near her buttocks. The CH's BF inflicted the bruising to the CH. An additional information report was received on 9/22/21 after SM gave birth to SC and medical staff were made aware of the SM's CPS history.

Report Determination: Unfounded **Date of Determination:** 12/02/2021

Basis for Determination:
Family members resided in 2 other counties in addition to Albany, and CWs in those counties assisted with interviews. SS was only observed, as she was non-verbal. All family members reported SS liked to jump on her bed, which had a metal bed frame and a thin mattress. They believed this to be the cause of the bruises. SS was in the custody of MU and deemed safe. There were no bruises observed by the CWs. The SS was assessed medically, including x-rays and blood work, and cleared. SC was born healthy with no concerns. The home was assessed and found to be cluttered with belongings but have clear pathways. Safe sleep education was provided, and a services referral was made for SM.

OCFS Review Results:
There was no casework activity from 12/30/20 to 9/22/21, and then again from 9/29/21 until 11/18/21, the date of the fatality.

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

Issue:
Timeliness of Determination

Summary:
This investigation was open until 12/2/21, 284 days overdue. There was a period of no casework activity for 266 days, and no documented justification as to why the investigation remained open. Additionally, there was no casework activity from 9/29/21 until 11/18/21, the date of the fatality.

Legal Reference:
SSL 424(7);18 NYCRR 432.2(b)(3)(iv)

Action:
The child protective service has the sole responsibility for making a determination within 60 days after receiving the report as to whether there is some credible evidence of child abuse and/or maltreatment so as either to "indicate" or "unfound" a report of child abuse and/or maltreatment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/17/2020	Sibling, Female, 4 Years	Grandparent, Female, 44 Years	Excessive Corporal Punishment	Unsubstantiated	Yes
	Sibling, Female, 4 Years	Grandparent, Female, 44 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received by Albany County Department for Children, Youth, and Families (ACDCYF) with concerns MGM struck the older surviving half-sibling with a paddle on her buttocks causing redness.

Report Determination: Unfounded | **Date of Determination:** 01/19/2021

Basis for Determination:
ACDCYF interviewed family members and collateral sources. MGM denied the allegations and reported she threatened the CH with a paddle, which is what she calls her hand (open palm). The CH reported MGM hits her on her arm and buttocks with a paddle, but it did not hurt or leave marks. Other household members had no concerns surrounding corporal punishment. Safe sleep provisions were observed. Both CHN were assessed as safe. The case was unfounded and closed.

OCFS Review Results:
The record did not reflect all collateral sources were contacted. ACDCYF was informed the older SS was not enrolled in the school SM claimed yet did not explore this further or verify the SS was attending school. The older SS's doctor reported the SS had a severe developmental concern; however, the record did not reflect any further questions were asked or if this was discussed with MGM and SM. ACDCYF did not make diligent efforts to interview the BF of the SS and a NOE was not sent. Services were not offered to the family. There were significant gaps in casework, with no casework activity from 1/20/20 to 4/2/20, 4/2/20 to 8/26/20, 9/22/20 to 11/10/20, and 11/10/20 to 1/14/21.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
ACDCYF was informed the eldest sibling was not enrolled in the school the mother claimed, yet did not explore this further with the mother or verify which school the child attended. The eldest sibling's doctor reported the child had a severe developmental concern; however, the record did not reflect any further questions were asked or if this was discussed with the mother or grandmother.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:

ACDCYF will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
ACDCYF had a current address for the biological father of the eldest sibling, but did not attempt any face-to face contacts. ACDCYF only attempted to reach him twice by phone.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Issue:
Failure to provide notice of report
Summary:
The record did not reflect if the eldest sibling's biological father was provided a Notice of Existence letter.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACDCYF will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Issue:
Timeliness of Determination
Summary:
This investigation was not closed until 1/19/21, 308 days past the required timeframe. There were significant gaps in casework, with no casework activity from 1/20/20 to 4/2/20, 4/2/20 to 8/26/20, 9/22/20 to 11/10/20, and 11/10/20 to 1/14/21. There was no explanation in the case record to justify the length of time this investigation remained open.
Legal Reference:
SSL 424(7);18 NYCRR 432.2(b)(3)(iv)
Action:
The child protective service has the sole responsibility for making a determination within 60 days after receiving the report as to whether there is some credible evidence of child abuse and/or maltreatment so as either to “indicate” or “unfound” a report of child abuse and/or maltreatment.

Issue:
Failure to Offer Appropriate Services
Summary:
The record did not reflect if services were offered to the family.
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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

07/23/2019	Sibling, Female, 2 Years	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Female, 2 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 22 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Female, 2 Years	Grandparent, Female, 44 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 2 Years	Grandparent, Female, 44 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Grandparent, Female, 44 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Female, 2 Years	Aunt/Uncle, Male, 20 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 2 Years	Aunt/Uncle, Male, 20 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Aunt/Uncle, Male, 20 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - MGM's Partner, Male, 59 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - MGM's Partner, Male, 59 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - MGM's Partner, Male, 59 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Grandparent, Female, 44 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Grandparent, Female, 44 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Aunt/Uncle, Male, 20 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Aunt/Uncle, Male, 20 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Other Adult - MGM's Partner, Male, 59 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Other Adult - MGM's Partner, Male, 59 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - BF of now 5yo SS, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received by Albany County Department for Children, Youth, and Families (ACDCYF) with concerns the surviving half-siblings were residing with SM, MGM, MU and OA in a deplorable home covered in dog feces, dog urine, dirty dishes, garbage, and mold. The adults failed to clean the home, and the SSs had gone without food

for several days. The younger SS's diapers were not regularly changed, and she suffered from medical issues as a result. The younger SS had an infection and SM failed to give her the prescribed medication. SM misused alcohol and would leave the SSs with MGM, who was not an appropriate caretaker due to illness.

Report Determination: Unfounded | **Date of Determination:** 08/26/2020

Basis for Determination:
ACDCYF interviewed household members, who denied the allegations. The CHN were observed and free from marks/bruises. The younger SS did not show any outward signs of an infection. The adults denied substance misuse when caring for the SSs. The home met minimal standards and was free from dog feces and urine. Ample food was observed. The case was unfounded and closed.

OCFS Review Results:
The CWs concluded the 2yo SS did not have an infection after observing and photographing the SS's genital area and noting she "did not have [an] infection." There were no attempts to contact the pediatrician or to have SM bring the SS to a medical provider. SM reported she was in treatment for MH issues, and MGM reported health issues; however, ACDCYF did not attempt to speak with their providers. MU obtained custody of the 2yo SS during this INV due to SM's declining MH. The verbal SS was not interviewed. There were significant gaps in casework activity. Services were not offered to the family. The SS's BF's were not interviewed.

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 did not reflect any attempts to interview the verbal surviving sibling, or the siblings' biological fathers.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:
The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
There were reported concerns that the children were not receiving appropriate medical care. The investigation also revealed the mother had significant mental health concerns and the grandmother had significant health concerns that may have impacted their caretaking abilities. The record did not reflect providers were contacted as collateral sources.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
ACDCYF will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
The allegations surrounding the SS's possible infections were not fully explored, as her pediatrician was not contacted and SM was not prompted to have the child seen medically. SM said SS saw her Dr on 7/19/19, but this was not confirmed. The CWs visually assessed SS's vaginal area and determined there was no sign of infection without seeking the opinion or diagnosis of a medical professional.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
Prior to making a determination of a report of abuse and/or maltreatment, the investigation conducted by the child protective service shall include a determination of the nature, extent and cause of any condition enumerated in the report.

Issue:
Timeliness of Determination

Summary:
The investigation was not closed until 8/26/20, 340 days past the required timeframe. There were significant gaps in casework, with no casework activity from 8/12/19 to 10/15/19, 10/15/19 to 1/17/20, 1/17/20 to 4/2/20, and 4/2/20 to 8/26/20. There was no documented justification as to why the case remained open.

Legal Reference:
SSL 424(7);18 NYCRR 432.2(b)(3)(iv)

Action:
The child protective service has the sole responsibility for making a determination within 60 days after receiving the report as to whether there is some credible evidence of child abuse and/or maltreatment so as either to "indicate" or "unfound" a report of child abuse and/or maltreatment.

Issue:
Failure to Offer Appropriate Services

Summary:
The record did not reflect if services were offered to the family.

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.

[redacted]

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

In 2014, the parent substitute was named as a subject in a CPS investigation with allegations of IG, LS, and LMC regarding his now eight-year-old child and an unrelated child. This investigation was unfounded and closed.

Known CPS History Outside of NYS

CPS history was found for the parent substitute in another state, involving his now eight-year-old child. An investigation revealed the parent substitute bit and grabbed the child, who was one year old at the time. The child sustained bruising and a bite mark on his arm. A full stay away order of protection was issued for that child, until he turns 18 years old.

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

Action:	Per the OCFS CPS Manual, photographs of children who may be victims of abuse or maltreatment should be taken or arranged for whenever there are visible physical injuries or trauma. In the 7/23/19 case, pictures were taken when there were no visible physical injuries or trauma.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No