Child Fatality Report

Report Identification Number: SY-20-007

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

Issue Date: Jul 03, 2020

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: 14 year(s)
Jurisdiction: Cortland
Gender: Male
Date of Death: 02/15/2020
Initial Date OCFS Notified: 02/15/2020

Presenting Information

An SCR report alleged the father did not provide adequate supervision to the 14-year-old male subject child who was autistic, had a history of wandering off and required constant supervision. While unsupervised, the child played near a creek and fell into the water. The child was able to pull himself out of the water. The father had not noticed the child left the home for approximately an hour. When the father found the child, he was unresponsive and laying on a snowbank. The father called 911, and when they arrived, they performed CPR. The child was transported to the hospital where staff attempted life-saving measures for approximately 2 hours. At 7:38 PM, the child was pronounced deceased. A subsequent report was made to the SCR regarding the child's death. The mother and siblings had unknown roles.

Executive Summary

This fatality report concerns the death of the 14-year-old male subject child that occurred on 2/15/2020. Reports were made to the SCR regarding the fatal incident and subsequent death. The child died unexpectedly while in the care of his father. The child and his siblings, ages 11 and 12 years, resided with the mother and visited the father on weekends. The siblings were assessed to be safe in the mother’s care throughout the investigation.

Cortland County Department of Social Services (CCDSS) coordinated investigative efforts with law enforcement upon the receipt of the initial report regarding concerns the child went missing while in the father’s care. The child was found unresponsive and not breathing along the shoreline of a creek. He was transported to the hospital where he was ultimately pronounced deceased. An autopsy was performed, and the cause of death was environmental hypothermia as the result of a fall into a creek with a contributory condition of Autism. The manner of death was accidental.

The father and the siblings reported being in the home with the child prior to noticing he had left. The family realized the child was not in the home when the father asked the child a question, and he did not respond. The child had Autism and had limited speech. Due to the child’s Autism, he required a higher level of supervision than the siblings. The father looked for the child outside, and asked the neighbors for help in the search. 911 was contacted and a search party discovered the child face-down in the snow next to a creek. The child was unresponsive and not breathing. He was transported to the hospital where he was placed on a ventilator until he succumbed to his injuries and was pronounced deceased.

CCDSS gathered information regarding the fatal incident and death from the family, first responders, hospital staff and the coroner.

CCDSS made home visits throughout the investigation to assess the safety of the siblings. Additionally, an abundance of services including grief counseling and funeral assistance were offered. The allegations of Inadequate Guardianship, Lack of Supervision, Internal Injuries and DOA/Fatality were substantiated against the father regarding the child. CCDSS documented the father knew the child required a higher level of supervision yet allowed the child to enter and exit the home alone. The child was out of the home for at least an hour prior to the father noticing. The father did not provide the child with the level of care he required, and as a result, the child sustained injuries that caused his death.

Although CCDSS appropriately encouraged the parents to allow the siblings to be in the mother’s care, the Safety Assessment tools did not accurately reflect case circumstances. The Safety Assessments noted the children to be in

immediate or impending danger throughout the investigation despite having discontinued contact with the father. Additionally, the case record contained progress notes that were not entered contemporaneously with their event dates.

In addition to services offered to the family in response to the fatality, CCDSS offered the family Preventive Services as there was a very high-risk rating; however, the services were declined. CCDSS' documentation of interviews with family members and collaterals reflected that of best casework practice. CCDSS completed a thorough investigation and closed the cases on 5/4/2020.

PIP Requirement

The family had CPS history in both Cortland and Chenango Counties; each will submit a PIPs to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the counties have taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, counties 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:

Cortland County conducted a thorough and appropriate investigation.

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 was appropriately determined and services were offered to the family.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Progress notes were not entered contemporaneously with their event dates. Some progress notes were entered two months after their event dates.
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.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	Although the siblings were no longer in the care of the father, the Safety Assessments reflected the siblings were in immediate or impending danger due to the father's mental health instability.
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 with regard to immediate or impending safety concerns.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/15/2020 **Time of Death:** 07:38 PM

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

County where fatality incident occurred: Cortland
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? No - but needed
At time of incident supervisor was:

☐ Drug Impaired ☒ Absent
☐ Alcohol Impaired ☐ Asleep
☒ Distracted ☐ Impaired by illness
☐ Impaired by disability ☐ 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	14 Year(s)
Deceased Child's Household	Mother	No Role	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	42 Year(s)

LDSS Response

On 2/15/2020, CCDSS received a report from the SCR alleging the 14-year-old subject child (SC) was found unresponsive near a creek. The report alleged the father did not provide adequate supervision to the SC which resulted in the SC leaving the home and falling into a creek. The SC sustained life-threatening injuries and was placed on life support. He succumbed to his injuries and was pronounced deceased at 7:38 PM.

Within the first 24 hours of the investigation, CCDSS coordinated investigative efforts with LE, contacted the sources of the reports, noted a CPS history check and spoke with collateral contacts. The DA and ME's offices were notified of the death. CCDSS contacted the mother. The parents were together during the call and agreed the siblings would not be in the father's care as the case was investigated. On 5/16/2020, CCDSS met with the mother and siblings at the CAC, where the children were interviewed separately and privately.

The 12-year-old sibling said the SC often went outside unsupervised when they visited the father. Oftentimes the father would not notice the SC left, as the father would be watching television and it was common for the SC to go along the railroad tracks and creek. On the day of the fatal incident, the SC went in and out of the house several times without asking. The 12-year-old sibling watched a movie with the father for about two hours before the father noticed the SC was not home. The father immediately went to look for the SC and saw footprints leading to the creek. The 12-year-old said the SC required constant supervision, but he was not always supervised at the father's home. The sibling did not provide further information about the fatal incident.

The 11-year-old sibling was upstairs playing with her friend while the father and sibling watched a movie. She said the SC spent most of his time alone in his room. The SC would often leave the father's home unsupervised for about an hour. The sibling said the SC left the house on prior visits and the father would locate the SC the creek and railroad.

The father said he and the mother exchanged the children around 10:00 AM on 2/15/2020. Around 1:00 PM, the father watched a movie with the 12-year-old sibling while the SC went in and out of his bedroom. The SC played outside unsupervised for approximately a half hour prior to eating lunch. An hour after lunch, the father asked the SC if he wanted a snack, but the SC did not respond. The exact time it was discovered the SC was not in the home remained unknown. After learning the SC was not home, the father went to look for him, observing footprints in the snow. The father texted a neighbor at 3:30 PM, asking if the SC had been seen, but to no avail. Around 4:30 PM, the father saw the tracks in the snow and called 911 as he could not find the SC and thought he may have fallen through the ice. A search party formed, and a neighbor discovered the SC's coat and boots next to the water.

First responders saw the SC face-down in the snow. The SC was unresponsive and not breathing. He was transported to the hospital, where life-saving measures were performed. First responders said the tracks in the snow appeared to be from the

SC playing on the ice. LE deemed the death an accident and no criminal charges were filed.

The mother said she received a call from the father telling her that the SC was on a ventilator and to go to the hospital. She was told the SC's body was being warmed after being discovered next to the creek but died as a result of hypothermia.

CCDSS offered an abundance of services to the family including bereavement services and burial assistance. At the time of case closure, the father declined the services for himself. The mother and siblings were not engaged in counseling services at the time of case closure despite being offered assistance. CCDSS appropriately determined and closed the case after conducting a thorough investigation.

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: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Cortland 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
054088 - Deceased Child, Male, 14 Yrs	054092 - Father, Male, 42 Year(s)	DOA / Fatality	Substantiated
054088 - Deceased Child, Male, 14 Yrs	054092 - Father, Male, 42 Year(s)	Inadequate Guardianship	Substantiated
054088 - Deceased Child, Male, 14 Yrs	054092 - Father, Male, 42 Year(s)	Internal Injuries	Substantiated
054088 - Deceased Child, Male, 14 Yrs	054092 - Father, Male, 42 Year(s)	Lack of Supervision	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:

Some progress notes were not entered contemporaneously with their event dates. The record did not reflect attempts were made to interview the 11-year-old sibling's friend, who was visiting at the time of the fatal incident.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No

Explain:
The mother declined services for the siblings in response to the fatality as she did not identify a service need for them.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents declined services from CCDSS stating they have strong support systems.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
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

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)
04/11/2019	Deceased Child, Male, 13 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 13 Years	Mother, Female, 34 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
An SCR report received by Chenango County alleged on 4/11/19, the 13-year-old subject child had suspicious injuries, with a scrape under his right eye and bruising on the left side of his neck, resembling fingerprints. There was bruising on his hand and the back of his head appeared to have hair pulled out. The injuries were suspected to have been inflicted by the mother.

Report Determination: Unfounded | **Date of Determination:** 06/19/2019

Basis for Determination:
The allegations of Inadequate Guardianship and Lacerations, Bruises and Welts were unsubstantiated against the mother regarding the subject child. The child was non-verbal and was not able to communicate how he sustained the injuries. The child was observed to bite and hit himself when he was upset. The mother reported the child was fighting with his brother and after the fight ended, the child continued to hit himself. The mother acted by restraining the child. The investigation did not reveal credible evidence to support the mother caused the child's injuries.

OCFS Review Results:
The investigation was initiated timely and a CPS history check was documented. Appropriate collateral contacts were made. The record did not reflect the father was provided with written notice of the report.

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

Issue:
Failure to provide notice of report
Summary:

Although the father was made aware of the SCR report, the record did not reflect he was provided with a written notice of existence.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

Chenango County will mail or deliver notification letters to subject(s), parent(s), and any other adult named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

Although the father had weekly visitation with the children, the record did not reflect his home was assessed for safety and risk. Additionally, although the reported concerns were addressed with the family, an overall assessment of safety and risk was not documented. Therefore, the investigation was closed with a predetermination of safety and risk.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

Chenango County will prioritize making an adequate assessment of safety and risk to all named children and continue an on-going assessment of safety and risk throughout the length of the investigation. The children's homes will be assessed for safety and risk, and information will be gathered regarding overall safety and risk. The allegations will not be allegation driven.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Progress notes were not entered contemporaneously to their event dates. Progress notes were entered two months after their event dates.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/12/2018	Deceased Child, Male, 12 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 11 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 10 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	

Report Summary:

An SCR report alleged on 11/11/18, the parents were involved in a domestic violence incident including verbal and physical violence in the presence of the children. The father grabbed the mother by her genitals over her clothes. There was police intervention. The role of the mother was unknown.

Report Determination: Indicated

Date of Determination: 12/03/2018

Basis for Determination:

The allegation of Inadequate Guardianship was substantiated against the father with regard to the children. The investigation revealed the father sexually assaulted the mother in the presence of the children and the father was arrested.

An Order of Protection was granted as a result of the father's actions and subsequent arrest. The parents separated and the father did not have contact with the children at the time of case closure.

OCFS Review Results:
The investigation was initiated timely, a CPS history check was noted, and written notice of the report was provided. The record did not reflect the father was interviewed. The Safety Assessments and Risk Assessment Profile were completed accurately. The contact made with collateral sources was exemplary.

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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
Although the father was mailed an appointment request, the record did not reflect additional attempts were made to interview the father, who was the subject of the report.

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

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

[redacted]

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

The family had a CPS history throughout New York.

03/12/06 - 06/02/06 An SCR report was substantiated against the father for Inadequate Guardianship of the child. The mother was unsubstantiated for the same allegation. The parents were unsubstantiated for Parent Drug/Alcohol Use regarding the child.

04/06/10 - 06/14/10 An SCR report was tracked FAR. The allegations reported to the SCR was Inadequate Guardianship against the parents regarding the children.

05/31/11 - 07/22/11 An SCR repot was made regarding the subject child regarding Inadequate Food/Clothing/Shelter, Inadequate Guardianship and Lacerations/Bruises and Welts. The report was made against a daycare.

01/15/15 - 12/08/15 An SCR report alleged the father provided Inadequate Guardianship to the children. The allegation was substantiated.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

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