Child Fatality Report

Report Identification Number: AL-20-009

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

Issue Date: Sep 11, 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: 2 month(s)
Jurisdiction: Albany
Gender: Male
Date of Death: 04/03/2020
Initial Date OCFS Notified: 04/03/2020

Presenting Information

Albany County Department of Children, Youth, and Families (ACDCYF) received a report from the SCR on 4/3/20 alleging the 2-month-old subject child passed away in the care of his mother and father. The mother placed the subject child in his car seat for a nap around 12PM and went to the store, leaving the subject child in the care of the father. The mother returned from the store around 1PM but did not immediately check on the child. When the mother checked on the subject child, she found him unresponsive. The mother called 911 and the child was transported to the hospital where he was pronounced dead after 3PM.

Executive Summary

Albany County Department of Children, Youth, and Families received a report from the SCR on 4/3/20, concerning the death of the 2-month-old subject child. The child was found unresponsive in his car seat at home on the same date.

The subject child resided at home with the mother. The father was transient, but would stay at the home with the mother and subject child frequently. The mother had two other children who lived with their father; they were assessed immediately upon receipt of the report and deemed safe in their father's care. It was learned the father of the subject child had 4 children with different mothers. Those siblings were assessed to be safe in the care of their mothers.

It was learned the father stayed at the home the night prior to the death. The mother woke around 8AM and fed the subject child but the child was fussy and did not eat an amount typical for him. The mother placed the child in his car seat and rocked him until he fell asleep. At around 11:30AM, the mother went to run errands and left the subject child in the care of his father. At the time the mother left the home, the subject child remained napping in his car seat while the father napped on a blow-up mattress adjacent to the car seat. The mother reportedly returned home around 2PM and made lunch prior to checking on the subject child. During the time the mother returned home and checked on the child, the father left the home to run errands. The mother found the child unresponsive and called 911 at 2:42PM. The mother performed CPR at the direction of the 911 operator while awaiting the arrival of EMS. EMS responded to the home and transported the subject child to the hospital where he was pronounced deceased shortly after 3PM.

Preliminary autopsy results were received on 4/4/20 and it was learned the subject child had old healing rib fractures and new re-broken rib fractures. There was blood in the child's chest cavity, and he had pneumonia. Due to the preliminary findings, an immediate safety plan was put in place for all the siblings. In communication with the mother, father, and non-respondent parents of all siblings, it was determined the mother and father would not have any contact with the siblings. All adults were receptive to the safety plan.

ACDCYF completed a joint investigation with Albany Police Department. At the time of this writing, the criminal case remained open. The final autopsy was completed. The autopsy revealed multiple rib fractures, pleural effusion, early acute bronchopneumonia, pulmonary respiratory bronchiolitis, and right accessory pulmonary lobe. The autopsy further explained the death was due to respiratory failure resulting from multiple rib fractures of varying age with early acute Bronchopneumonia.

ACDCYF contacted all necessary collaterals and determined there was credible evidence to substantiate the allegations of inadequate guardianship, fractures, and DOA/fatality against the mother and father regarding the subject child. In speaking with the ME and medical personnel, ACDCYF learned the rib fractures were in different stages of healing and

were from repeated abuse. The ME elaborated the fractures were a deliberate application of force. ACDCYF was unable to determine whether the mother or father caused the injuries. The father was receptive to preventive services and was working with ACDCYF at the time of this writing. The mother was not compliant with services and reported she would only work with the Department once ordered to do so by the court. At the time of this writing, ACDCYF planned to file an Article 10 Neglect petition against the mother and father in Family Court.

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 thoroughly investigated the incident and appropriately closed the case.

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

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:
Casework activity was commensurate with best casework practice. At the time of this writing, the case was opened for Preventive Services.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 04/03/2020 **Time of Death:** 03:11 PM

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: 02:25 PM
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? 1 Hours
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☒ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☐ Asleep
- ☐ Impaired by illness
- ☐ 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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)

LDSS Response

On 4/3/20, ACDCYF received the SCR report and initiated their investigation promptly by coordinating with LE and sharing information. In addition to LE, ACDCYF contacted the source, hospital, district attorney, the parents, and all related medical personnel. ACDCYF reviewed CPS history which revealed that both parents were known to the system as confirmed subjects. These actions were completed on the date of the initial SCR report, and further contact with the family and collaterals continued throughout the length of the investigation.

The subject child had 6 half-siblings; 2 who resided with the their father, and 4 of whom resided with their respective mothers. The safety of the siblings was assessed, and it was determined they were safe in the care of the non-respondent

parents. A safety plan was deemed necessary due to the circumstances surrounding the death and ACDCYF closely monitored that the plan was being followed for the duration of the investigation.

Through interviews conducted with family members and first responders, it was learned the subject child was not eating regularly in the days leading up to the death. Additionally, the child was not going to the bathroom normally. The mother ascribed this to the child being gassy and gave him medication to relieve the gas. The mother did not consult medical professionals regarding the concern, stating it was a frequent occurrence and the doctor previously prescribed the gas remedy. The mother attempted to feed the child around 8AM on the day of the death. The child was fussy, so the mother placed him in his car seat and rocked him until he fell asleep. The mother and father slept on the air mattress adjacent to the car seat for a few hours. Around 11:30AM, the mother went to run errands and left the subject child at home with the father. The father and subject child remained sleeping while the mother was gone. The mother returned to the home around 2PM and the father left immediately thereafter. The mother made food and then checked on the child around 2:30PM and found the child unresponsive at that time. The mother contacted 911 and began CPR at the instruction of the 911 operator. EMS arrived and transported the child to the hospital where he was pronounced dead at 3:11PM.

The father was interviewed, and he corroborated the information. The father reported he did not live with the mother but stayed with her at times. The father reported he did not have a permanent residence. The father stated he did not have many parenting skills and was just learning how to make the subject child a bottle. The father reported he only held the child about 3 or 4 times and always in the presence of the mother. The father reported he rarely cared for the subject child on his own. The day of the fatal incident was one of the few times he had been left alone with the child. The father denied regular and consistent contact with his other children and stated he did not parent them alone.

ACDCYF received pertinent medical records and learned the subject child had a history of slight pre-term birth. On the day of the death, the child presented to the ER unresponsive and asystolic. The autopsy revealed the child had 7 fractured ribs on his left side and 10 fractured ribs on his right side, all in different stages of healing. ACDCYF contacted the ME to gather additional information related to the findings in the autopsy report. In speaking with the ME, ACDCYF learned the rib fractures were a deliberate application of force. There was an accumulation of fluid as a result of the injury. The ME verbalized the pneumonia was likely related to the rib fractures. The fractures were in different stages of healing with the oldest fracture being 11-15 days old.

ACDCYF conducted interviews with all non-respondent parents. The father of the mother's children reported he had no significant concerns for the mother. He reported she historically was unable to care for the siblings and relinquished the care to him. He reported the siblings did not have frequent contact with the mother and had not seen her since the birth of the subject child. The mothers of the siblings reported the father was not involved in any of the siblings' lives. All mothers reported the father did not know how to parent and did not take an active roll in parenting any of the siblings. The non-respondent mothers denied any concerns that the father would injure any children. All denied seeing the father become physically aggressive.

ACDCYF accurately determined the allegations after conducting a thorough investigation. ACDCYF appropriately made a safety plan of the surviving siblings. ACDCYF closely monitored the plan by visiting the homes of the non-respondent parents. The parents were offered a multitude of services related to bereavement and mental health counseling. The father was receptive to services and ACDCYF provided him with a plethora of resources. Additionally, the father began working with Preventive Services and remained working with the services at the time of this writing. The mother was not compliant with ACDCYF and reported she would only complete services once they were court mandated. The case remained open for Preventive Services at the time of this writing and the safety plan for the siblings remained in place.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a medical 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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054852 - Deceased Child, Male, 2 Mons	054853 - Mother, Female, 25 Year(s)	DOA / Fatality	Substantiated
054852 - Deceased Child, Male, 2 Mons	054853 - Mother, Female, 25 Year(s)	Fractures	Substantiated
054852 - Deceased Child, Male, 2 Mons	054853 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
054852 - Deceased Child, Male, 2 Mons	054854 - Father, Male, 26 Year(s)	DOA / Fatality	Substantiated
054852 - Deceased Child, Male, 2 Mons	054854 - Father, Male, 26 Year(s)	Fractures	Substantiated
054852 - Deceased Child, Male, 2 Mons	054854 - Father, Male, 26 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 a variety of services to both the mother and father regarding bereavement and mental health counseling. Additionally, a Preventive Services case was opened to offer additional support while the Article 10 Neglect/Abuse petitions are processed in Family Court. At the time of this writing, the father was receptive to and working with Preventive Services. The mother refused to comply with Preventive Services and reported she would not engage until ordered to do so by the court.

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:
Though there were no other children in the home, both the mother and father had additional children that were in the care of the non-respondent parents. A safety plan was implemented that neither the mother nor the father were to have any contact with any of the surviving siblings due to the conditions surrounding the death.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Other, specify: Preventive Services

Additional information, if necessary:
ACDCYF offered a multitude of resources related to mental health and grief counseling. The father expressed needing assistance with housing and ACDCYF offered him a number of available resources at their disposal. ACDCYF coordinated with family members to implement a safety plan to keep the surviving siblings safe. Additionally, ACDCYF opened a Preventive Service case to offer additional assistance and support to the mother, father, surviving siblings, and non-respondent parents. The father was receptive to preventive services but the mother refused to comply stating that she would not engage until ordered to do so by the court.

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:
A variety of services were offered to the siblings related to counseling and Preventive Services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
A multitude of services were offered to the parents related to bereavement counseling and mental health counseling. Additionally, ACDCYF opened a Preventive Services case and began working with the father. The mother was not receptive to services at the time of this writing.

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?	Yes

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)

01/05/2020	Deceased Child, Male, 1 Days	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	No

Report Summary:
Rensselaer County Department of Social Services (RCDSS) received a report alleging the infant subject child was born with a positive toxicology for marijuana. The mother also tested positive at the time of the infant's birth. The mother admitted to using marijuana regularly throughout her pregnancy.

Report Determination: Unfounded | **Date of Determination:** 02/13/2020

Basis for Determination:
RCDSS determined there was no credible evidence to support the allegations. RCDSS found the infant did not suffer from withdrawal and the mother made all necessary provisions to care for the infant.

OCFS Review Results:
RCDSS completed timely and adequate safety and risk assessments. A Plan of Safe Care was completed and monitored by RCDSS. RCDSS provided multiple referrals to the family for substance abuse counseling and mental health services. Once all case objectives were met, RCDSS appropriately closed the case.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/18/2019	Sibling, Male, 5 Years	Other Adult - Father of the siblings, Male, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Sibling, Male, 5 Years	Other Adult - Father of the siblings, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Other Adult - Father of the siblings, Male, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Other Adult - Father of the siblings, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
Rensselaer County Department of Social Services (RCDSS) received a report from the SCR on 11/18/19 alleging the father of the siblings was unable to provide food for the siblings. As a result, the siblings were asking people for food and going hungry.

Report Determination: Unfounded | **Date of Determination:** 01/29/2020

Basis for Determination:
RCDSS determined there was no credible evidence to substantiate the allegations. Though the father of the siblings and the siblings were homeless, he provided them with adequate food and met all their basic needs. Additionally, family members assisted with caring for the siblings and providing for their needs.

OCFS Review Results:
RCDSS contacted all relevant collateral sources and assessed the safety of the siblings at regular intervals throughout the investigation. RCDSS collaborated with other agencies to assist the father with housing. RCDSS completed all necessary casework practice in a timely and adequate fashion. RCDSS appropriately determined and closed the investigation when services were deemed unnecessary and a thorough investigation was completed.

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

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

08/17/2017	Sibling, Male, 2 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 1 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Maternal Aunt, Female, 12 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 22 Years	Lack of Supervision	Unsubstantiated	
	Other Child - Maternal Aunt, Female, 12 Years	Mother, Female, 22 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
ACDCYF received a report from the SCR alleging the mother was diagnosed with Bipolar Disorder. A week earlier the mother attempted to kill the 1-year-old sibling by placing a receiving blanket over the child's head. The sibling did not receive any injuries. Additionally, an unrelated child in the mother's care was a child who was a Person In Need of Supervision (PINS) due to an unrelated incident. The mother was aware the unrelated child needed heightened supervision but failed to provide the necessary supervision. The unrelated child left the home and the mother allowed her to leave. There was reportedly an incident that took place between the mother and unrelated child previously where the mother hit the child's head into a wall.

Report Determination: Unfounded | **Date of Determination:** 02/06/2019

Basis for Determination:
ACDCYF determined there was no credible evidence to substantiate the allegations. The mother was found to provide appropriate supervision for the sibling as well as the unrelated child. During the course of the investigation, it was learned the unrelated child's behaviors became increasingly risky and the child was ultimately placed in the care and custody of OCFS in a residential facility.There was no credible evidence the mother had ever tried to smother the then 1-year-old sibling. At the time of investigation closure, the two siblings were residing with the paternal grandmother due to the mother and father of the siblings chronic homelessness.

OCFS Review Results:
ACDCYF did not accurately complete the Risk Assessment Profile in that they scored the mother and father as having adequate and appropriate housing. The case record reflected the father and siblings were homeless and residing in a shelter for the duration of the investigation. Additionally, the mother was homeless and residing in a separate shelter. An initial 7-day safety assessment was not recorded as being completed in CONNECTIONS. Many of the notes were added more than a year after their event dates. At the time of the investigation, there were several investigations with additional concerns opened concurrently, which were not consolidated into the initial investigation. The investigation was opened from 8/17/17 to 2/6/19 and the case record reflected casework contact with the alleged maltreated sibling did not occur at all from 9/13/17 until 10/24/18, a period more than a year.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
Concerns were reported to the SCR regarding the then 1yo SS, including allegations the mother attempted to smother her. The investigation was opened beyond the regulatory period and the record did not reflect the sibling was assessed regularly and consistently throughout the investigation and was not seen for more than a year prior to case closure. The alleged maltreated sibling was seen 6 times within the first 5 months of the investigation. The alleged maltreated sibling was last seen 1/25/18 and the investigation was not closed until 12 months later on 2/6/19. ACDCYF entered many of the progress notes more than a year after their event dates. A 7-day safety assessment was not documented in CONNECTIONS as being completed. The RAP score did not reflect that the mother and father of the siblings were homeless and residing in a shelter for the duration of the investigation.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
ACDCYF will complete and record progress notes, safety assessments and RAPs accurately and timely. ACDCYF will determine cases within 60 days of receiving 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)
08/10/2017	Sibling, Male, 2 Years	Other Adult - Father of the siblings, Male, 20 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Male, 2 Years	Other Adult - Father of the siblings, Male, 20 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
ACDCYF received an SCR report alleging the father of the siblings failed to provide food for the siblings. The then 2-year-old male sibling was missing meals in his father's care and appeared thinner. As a result, his health was negatively impacted.

Report Determination: Unfounded | **Date of Determination:** 01/22/2018

Basis for Determination:
ACDCYF determined there was no credible evidence to substantiate the allegations. ACDCYF observed the siblings and learned the father was feeding them appropriately and had obtained custody of the siblings through Albany County Family Court as the mother could not meet their needs.

OCFS Review Results:
ACDCYF did not accurately complete the Risk Assessment Profile in that they scored the father has having adequate and appropriate housing. The case record reflected the father and siblings were homeless and residing in a shelter for the duration of the investigation. Additionally, the mother was homeless and residing in a separate shelter. Collateral contact was not made with the sibling's medical provider despite concerns in the SCR report related to the child's health being negatively impacted due to missing meals.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP score did not reflect that the mother and father of the siblings were homeless and residing in a shelter for the duration of the investigation.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACDCYF will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
There were missed opportunities to gather collateral information from medical professionals. The record does not reflect that appropriate releases were signed in order for ACDCYF to speak with the siblings' primary care physician despite concerns that the 2yo sibling's health was being negatively impacted.
Legal Reference:

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

Action:

ACDCYF will make diligent efforts to contact collateral sources to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/20/2017	Sibling, Male, 2 Years	Other Adult - Father of the siblings, Male, 20 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 10 Months	Other Adult - Father of the siblings, Male, 20 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

Albany County Department of Children, Youth, and Families received an SCR report on 6/20/17 alleging the father of the siblings physically assaulted the mother with the siblings present.

Report Determination: Unfounded **Date of Determination:** 02/06/2019

Basis for Determination:

ACDCYF determined there was no credible evidence to support the allegations. There were instances of domestic violence from 2015, but no arrests were made. There were no recent concerns for domestic violence between the mother and father of the siblings. There were additional concerns that arose during the investigation, which were being investigated in investigations open concurrently.

OCFS Review Results:

Many of the notes were added more than a year after their event dates. At the time of the investigation, there were several investigations with additional concerns opened concurrently, which were not consolidated into this investigation. There were concerns regarding unknown individuals and children addressed throughout the notes that were not relevant to this SCR report and those individuals were not added to the household composition, though they were comprehensively interviewed. Additionally, the case record reflected ACDCYF focused on concerns regarding another household rather than concerns specific to this SCR report. Allegations related to the concerns were never added.

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

Issue:

Timeliness of Determination

Summary:

The investigation was opened from 6/20/17 to 2/6/19 and the case record reflects casework contact with the alleged maltreated children only occurred on 8/11/17, 1/18/18, and 1/25/19.

Legal Reference:

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

Action:

ACDCYF must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static (CPS Manual Chapter 6 section D page D-1 and D page D3).

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Multiple progress notes were not entered contemporaneously during the investigation, and were documented up to a year after the 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.

[redacted]

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

The father was listed as a confirmed subject on an indicated report from April 2013 regarding a spiral leg fracture to a 1-year-old unrelated child.The unrelated child was the father's girlfriend's child who sustained an unexplained fracture while in the care of the father and his girlfriend. It could not be confirmed who caused the injury so both adults were indicated.

Known CPS History Outside of NYS

There was no known 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