Child Fatality Report

Report Identification Number: AL-22-007

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

Issue Date: Jul 25, 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: 5 year(s)
Jurisdiction: Fulton
Gender: Female
Date of Death: 02/24/2022
Initial Date OCFS Notified: 03/03/2022

Presenting Information

On 2/24/22, Fulton County Department of Social Services (FCDSS) learned of the death of the 5-year-old female subject child that occurred on the same date. The family had a CPS investigation open at the time of the death. The SCR report alleged concerns regarding the grandmother's follow through with medical care for the subject child.

Executive Summary

On 2/24/22, FCDSS was notified by the hospital that the 5-year-old subject child passed away on the same date at 12:43AM. FCDSS had an open CPS investigation, which began on 2/11/22, and alleged that the subject child was at risk of death due to Lack of Medical Care by the grandmother. The subject child had missed necessary medical appointments and had an infection. At the time of her death, the subject child resided with her grandmother, 6-year-old sibling, 12-year-old uncle, and 15-year-old aunt. The grandfather was incarcerated, the father passed away in 2020, and the mother resided at a separate residence with two other surviving siblings, ages 1 and 2.

The subject child was medically fragile at birth and diagnosed with Short Bowel Syndrome. The mother was unable to meet the child's medical needs and, as a result, the grandmother obtained custody. The subject child had numerous doctors and specialists which were required to maintain her medical care; however, the grandmother had missed several appointments. On 2/11/22, the grandmother noticed that the subject child seemed fatigued, and her skin was discolored. The grandmother contacted medical professionals for further opinions and brought the subject child to the hospital the same day, where she remained until the time of her death. The subject child had an infection in her PICC line. On 2/24/22, the subject child was alert and playing on her iPad while at the hospital when she hemorrhaged. Life-saving measures were attempted; however, were unsuccessful and the child passed away.

Doctors were unable to say the outcome would have been prevented if the child had attended her missed medical appointments. The grandmother was offered bereavement services for herself and the family, but stated she planned to engage the entire family in counseling through the local mental health clinic. The CPS investigation open at the time of death, was indicated and closed on 3/29/22.

PIP Requirement
For citations identified in historical cases, each cited county will submit a PIP to the Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the respective LDSS' have taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, the respective LDSS' 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A

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

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:
Casework activity was commensurate with 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: 02/24/2022 **Time of Death:** 12:43 AM

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

County where fatality incident occurred:	Albany
Was 911 or local emergency number called?	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: Playing on an ipad at the hospital

Did child have supervision at time of incident leading to death? Yes

At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:
☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **Administering Medical Care**

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	Aunt/Uncle	No Role	Male	12 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	15 Year(s)
Deceased Child's Household	Deceased Child	No Role	Female	5 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	42 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	40 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)

LDSS Response

On 2/11/22, FCDSS received an SCR report with concerns about the grandmother obtaining appropriate medical care for the subject child. FCDSS initiated their investigation within 24 hours, and made casework and collateral contacts. Upon learning of the subject child's death on 2/24/22, FCDSS began gathering information regarding the circumstances of the fatality.

The mother and grandmother were interviewed on 2/11/22 regarding the circumstances that led to the subject child being hospitalized. The grandmother reported that the subject child appeared fatigued and contacted the child's doctor via text message with concern that her oxygen levels were low and that there was a possible infection in her PICC line. The grandmother informed the doctor that she would be bringing the subject child to the hospital. The grandmother confirmed medical appointments had been missed due to weather and car issues; however, noted that the child had an in-home nurse and attended specialist appointments every 3 months. The mother expressed no concern regarding the grandmother's care of the subject child at that time.

The subject child remained at the hospital from 2/11/22 until the time of her death on 2/24/22. The subject child had been in critical condition and in a coma for a period of time; however, regained consciousness and appeared to be recovering from the infection prior to her death. The grandmother and mother requested an autopsy be performed, though the results were not reflected in the case record. Hospital records noted the subject child's cause of death as pulmonary hemorrhage, with concerns of gastrointestinal hemorrhage, cardiac arrest, and tricuspid endocarditis. FCDSS made diligent efforts to coordinate with law enforcement throughout the CPS investigation. The 6-year-old sibling, 12-year-old uncle and 15-year-old aunt were assessed to be safe in the grandmother's care.

FCDSS substantiated the abuse allegation of Lack of Medical Care against the grandmother. The determination stated the subject child had not been seen by her pediatrician or specialists for over 1 year. FCDSS also noted the grandmother was difficult to contact and failed to communicate with the child's team of doctors until severe medical issues arose. The record reflected that the doctor did state the grandmother could be difficult to contact; however, was usually available via text message and would communicate when appointments needed to be canceled. FCDSS documented a conversation with the child's specialist, in which the doctor stated he was unable to say if the child had attended the missed medical appointments, it would have resulted in a different outcome. The information gathered during the investigation did not support that missed medical appointments had an impact on the child's medical condition, nor did it provide a fair preponderance of evidence for the indicated abuse allegation.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Coroner

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: Fulton County does not have an OCFS approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

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

Explain:
There was no SCR report surrounding the fatality; therefore, the safety assessments were not required. FCDSS did assess for the safety of the 6-year-old surviving sibling, the 12-year-old uncle and 15-year-old aunt.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
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? Yes
Explain:
Bereavement services were discussed with the grandmother, who reported that she and the grandfather felt all household members needed counseling. It is unknown if the family was engaged in counseling at the time the CPS investigation was closed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were discussed with the grandmother, who reported that she and the grandfather felt all household members needed counseling. It is unknown if the family was engaged in counseling at the time the CPS investigation was closed.

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

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)
02/11/2022	Deceased Child, Female, 5 Years	Grandparent, Female, 42 Years	Lack of Medical Care	Substantiated	Yes

Report Summary:
The SCR report alleged the subject child was extremely medically fragile and required follow-up medical care in order to ensure that she received the necessary nutrition and care to survive. The grandmother was aware of the seriousness of the situation but did not ensure that the subject child received the necessary medical care. The subject child was extremely anemic; there was concern for pneumonia and infection in her PICC line. The subject child was stated to be at risk of death due to lack of medical care.

Report Determination: Indicated | **Date of Determination:** 03/29/2022

Basis for Determination:
The subject child was born medically fragile and required a higher level of care, including follow up appointments with specialists and the pediatrician. On 2/11/22, the subject child was brought to the emergency room with an infection and transferred to another hospital, where she passed away on 2/24/22. During the investigation, it was discovered there were numerous medical appointment cancellations and no-shows, and doctors noted they had not seen the subject child in over

a year. The grandmother was difficult to contact with and did not return calls in a timely manner. The grandmother failed to communicate with doctors and only reached out when the subject child became ill.

OCFS Review Results:
FCDSS initiated their investigation within 24-hours, made collateral contacts and interviewed all household members. The subject child passed away during the investigation, and FCDSS made appropriate collateral contacts pertaining to the death. FCDSS indicated abuse allegations of Lack of Medical Care against the grandmother.

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

Issue:
Failure to report death of child in open CPS or Preventive/CPS services case in timely manner

Summary:
FCDSS did not report the fatality to OCFS until 8 days after learning of the death.

Legal Reference:
06-OCFS-LCM-13

Action:
FCDSS will complete the OCFS 7065 form and send it to the appropriate Regional Office of the New York State Office of Children and Family Services within 72 hours of the injury, accident, or death.

Issue:
Appropriateness of allegation determination

Summary:
FCDSS indicated the allegation of LMC against the grandmother regarding the subject child; however, doctors were unable to say if the child had attended missed appointments, it would have resulted in a different outcome. The in-home nurse had no concern for the grandmother's ability to provide care, and the record did not support that the missed appointments had an impact on the child's condition.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
FCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Albany Regional Office if further guidance is needed.

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/25/2021	Sibling, Female, 1 Months	Mother, Female, 22 Years	Lack of Medical Care	Unsubstantiated	Yes
	Sibling, Female, 1 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 1 Months	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Months	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The SCR report alleged the mother had a history of substance misuse, including being on probation and attending substance misuse counseling. The mother failed to address her substance misuse and was not in treatment. Instead, the

mother continued to use substances while caring for the 1-month-old and 1-year-old. While impaired, the mother was unable to adequately care for the children and roamed the streets with the children while using substances. The 1-month-old sibling was born with a lung condition which required medical care; however, the mother failed to follow through with medical recommendations for the child to see a lung specialist and as a result, the lung condition worsened.

Report Determination: Unfounded | **Date of Determination:** 03/29/2022

Basis for Determination:
The mother denied the allegations of the report, stating that she did have a history of substance misuse; however, had not used since prior to having the 1-month-old. The mother reported the 1-month-old had a small hole in her heart at birth but had been seen by specialists who told her the child would grow out of it. The mother stated that the 1-month-old child had no other medical needs that required follow-up. The 1-year-old and 1-month-old were deemed to be safe with the mother. During the investigation, the subject child passed away. The subject child was in the care of the grandmother at the time, and the mother denied having regular or consistent contact with the child.

OCFS Review Results:
ACDCYF (Albany County Department for Children, Youth and Families) had their investigation open for over a year. During the investigation, ACDCYF did not make necessary contact with collaterals to fully assess the safety of the 1-month-old and 1-year-old siblings for over a year, until after the subject child's death. There was a period from 3/1/21-10/1/21 where there was no documented casework, until an additional information report was received.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
ACDCYF concluded at the time of the 7-day safety assessment that there were no safety factors; however, ACDCYF had not interviewed the mother regarding the concerns for the 1-month-old's medical condition and had not contacted any medical collaterals during that time. Therefore, there was not enough information at that time to determine there were no safety factors present.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Within seven days of receiving a report, ACDCYF will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Issue:
Timeliness of Determination
Summary:
The investigation was open for over a year, from 2/25/21-3/29/22 with no documented casework for a 7-month period.
Legal Reference:
SSL 424(7);18 NYCRR 432.2(b)(3)(iv)
Action:
ACDCYF will make a determination of either "indicated" or "unfounded" within 60 days after receiving the report.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
There was a period from 3/1/21-10/1/21 where there was no casework conducted, other than one case conference. There was no contact with the mother, or continued assessment of the children's safety during that timeframe.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
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.

Issue:
Failure to provide notice of report
Summary:
The record did not reflect ACDCYF provided written notification of the report to the mother.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACDCYF will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
The mother expressed concern to ACDCYF regarding the grandmother's mental health and the grandfather's criminal history; however, the record did not reflect that information being explored further, despite the mother's 6-year-old being in the care of the grandparents at the time of this writing.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
ACDCYF will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACDCYF did not attempt to contact the source of the report for over a year, at which time the source's phone number had been changed. Therefore, ACDCYF was unable to verify the information provided in the initial report. ACDCYF also did not attempt to contact medical collaterals for over a year, until after the subject child's death, when there was concern for the 1-month-old's medical condition.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACDCYF will contact, or make diligent efforts to contact the source of all SCR reports to verify the adequacy of the report. In addition, ACDCYF will obtain information from collaterals who may have information pertinent to the allegations and safety of the children.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/04/2019	Deceased Child, Female, 3 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 3 Years	Grandparent, Female, 39 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The SCR report alleged the subject child had a GI medical condition that required regular follow up with the doctor. The

subject child also had an IV iron supplement condition. The grandmother had not followed through with the subject child's medical appointments. The subject child had not visited the GI doctor in 8 months. The subject child was admitted to the hospital due to a high fever and infection. The subject child's hemoglobin levels were low and she had missed appointments with both doctors.

Report Determination: Unfounded | **Date of Determination:** 04/23/2020

Basis for Determination:
FCDSS found that there was no credible evidence to substantiate the allegations. There were no concerns for the subject child not being cared for. Medical records were obtained from various collaterals with no concerns noted. FCDSS was able to speak with a registered nurse in the home, who also had no concerns that the hospitalization was due to lack of care by the grandmother. The grandmother stated that the subject child had missed appointments but she had always been in contact with the doctor about them. One appointment was missed due to Family Court and the other was cancelled by the doctor. When the subject child had a fever, the grandmother immediately brought her to the hospital.

OCFS Review Results:
FCDSS initiated their investigation within 24-hours, contacted the source of the report, spoke with collaterals, and conducted interviews of the parents. FCDSS also interviewed the grandmother and other children residing in the home when age appropriate. FCDSS completed the Risk Assessment Profile and 7-day safety assessment timely and accurately; however, the record does not reflect FCDSS conducted a face-to-face interview with the grandfather, who was a caretaker for the children and resided in the home. The record did not reflect the grandfather was provided written notice of the report. The CPS history check was completed late on 10/10/19.

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

Issue:
Review of CPS History
Summary:
The CPS history check was completed untimely on 10/10/19.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, FCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, FCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
The grandfather was residing in the home and identified as a caretaker for the children; however, the record does not reflect that FCDSS completed a face-to-face interview with the grandfather.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
FCDSS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Failure to provide notice of report
Summary:
The record did not reflect FCDSS provided written notification of the report to the grandfather.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
FCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

[redacted]

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

Between 2011 and 2018, there were eight unfounded investigations, four indicated investigations, and one Family Assessment Response case. Common allegations among the reports include IG, LMED, EDNG, and IFCS. The indicated reports from 2014, 2016 and two from 2017 were regarding the grandmother being unable to provide adequate supervision for her child, the surviving sibling hitting her head during a domestic violence incident between the mother and father, the grandmother's children not attending school, and the mother and father being unable to care for the subject child's medical needs.

Known CPS History Outside of NYS

There is no known history outside of New York State.

Preventive Services History

The mother and father had two voluntary cases opened. The first case opened on 10/25/16, as the result of the surviving sibling sustaining a head injury during a domestic violence incident between the mother and father, and the mother giving birth to the subject child and her twin sister, who passed away in the hospital. The case was closed on 12/7/16 because the family moved out of county. The second case opened on 12/20/16 due to the subject child being medically fragile, and the parents having untreated mental health and unstable housing. The case was closed on 7/14/17 due to the family again moving out of county.

Foster Care Placement History

The grandmother had one voluntary case opened on 5/15/14 to assist her, as both of her children were in placement due to their high-risk behaviors. After multiple placements, both children returned home, and the grandmother requested the case be closed after the court order ended and the case was closed on 8/19/2015.

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