Report Identification Number: NY-22-027

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

Issue Date: Oct 14, 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Jurisdiction: Kings
Date of Death: 04/24/2022
Age: 2 year(s)
Gender: Female
Initial Date OCFS Notified: 04/24/2022

Presenting Information

An SCR report alleged on 4/24/22, around 2:00 AM, the 2-year-old child went to sleep on the couch in the living room. At 10:34 AM, the mother checked on the child and found her face-down on the couch, not breathing. The mother turned the child over onto her back, performed CPR and called 911. The grandmother and the aunt were present with the mother throughout the incident. It was unknown what actions the grandmother and aunt took during this time. EMS performed CPR while transporting the child to the hospital, where she was pronounced deceased at 11:22 AM. The mother, grandmother and aunt had no explanation for her death. A duplicate SCR report was received on 4/25/22.

Executive Summary

This report concerns the death of the 2-year-old child that occurred on 4/24/22. An SCR report was made on the same day. The report alleged the mother found the child face-down on the couch. The child was unresponsive, not breathing and subsequently passed away. At the time of the fatal incident, the child was at the maternal grandmother's home with her siblings, aged 4 and 8 years. An aunt and her 2-month-old child and a 6-year-old cousin (child of another aunt) were also at the home. The children were assessed to be safe in the care of their mothers.

The Administration for Children Services (ACS) coordinated investigative efforts with law enforcement upon receipt of the report. There were no criminal charges pending at the time this report was written. An autopsy was performed; however, the final autopsy report was not yet available at the time of this writing. The medical examiner noted the child's body did not show any "indication or suspicion around the cause of death."

The family reported that on 4/23/22, the grandmother watched the children while the aunts and mother went out for a celebration. The children laid down to watch a movie until they fell asleep. There were no concerns for any of the children and the child acted normally. The adults returned home after the rest of the family went to sleep. On the morning of 4/24/22, the grandmother heard the mother screaming and the child would not rouse. The mother began performing CPR and called 911. First responders arrived at the home, took over resuscitation efforts and transported the child to the hospital, where she was pronounced deceased.

ACS made collateral contacts including medical staff, first responders, ACS staff, and relatives. Hospital staff reported the child was dead upon arrival to the hospital. Information was gathered from a hospital doctor that the child had a preexisting medical condition since birth that required special treatment in the past, and the child had experienced a neurological disorder. The record did not reflect whether ACS corroborated this information with the child's pediatrician or a specialist. Additionally, the record reflected the mother had a history of not providing adequate medical care follow-ups for her children; however, this was not documented to have been further explored by ACS.

ACS conducted home visits and met with family members. An aunt, who was present at the time the child was found unresponsive, declined to cooperate with ACS's investigation. The record did not reflect attempts to contact the fathers of the children regarding the SCR report. Although completed timely, the Safety Assessments and Risk Assessment Profile did not accurately reflect documented case circumstances. The record contained information that the mother was inconsistent with seeking recommended medical follow-up appointments regarding the child and the 4-year-old sibling; however, the record did not reflect attempts were made to contact the medical providers of the children. The investigation remained open at the time this report was written.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS 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?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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

Explain:

The investigation remained open at the time this report was written.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:

Casework activity was not commensurate with case circumstances as the Safety Assessments and Risk Assessment Profile did not accurately reflect case circumstances.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP did not reflect there was an infant in the family unit despite the 2-month-old cousin being listed on the report.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The Safety Assessments noted the mother's marijuana misuse was a Safety Factor; however, case documentation did not reflect the mother's marijuana misuse had a negative impact on her ability to care for the children.
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 regarding safety.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/24/2022 **Time of Death:** 11:22 AM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 10:32 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] 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	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	57 Year(s)
Other Household 2	Aunt/Uncle	Alleged Perpetrator	Female	28 Year(s)
Other Household 2	Other Child - Cousin	No Role	Male	6 Year(s)
Other Household 3	Other Child - Cousin	No Role	Male	2 Month(s)

LDSS Response

On 4/24/22, ACS received the SCR report. Within the first 24 hours of the investigation ACS completed a CPS history check, coordinated investigative efforts with LE, contacted the source of the report and conducted a home visit. The ME and district attorney's offices were made aware of the death.

LE noted the subject child (SC) was asleep on the couch at 2:00 AM, and the subject mother (SM) attempted to wake her around 10:30 AM. The SC was not breathing. The SM performed CPR and called 911. LE said the SC had pre-existing medical conditions and was impacted by a neurological disorder.

The maternal grandmother (MGM) reported that on 4/23/22, she watched her grandchildren while their mothers went out to celebrate a birthday. The children appeared fine and played until they laid down around 9:00 PM and fell asleep. The MGM reported around 8:00 AM, the SM attempted to wake the SC as she was preparing to leave the MGM's home and the SM screamed. The MGM, SM and children attempted to wake the SC, who was blue and was not breathing. The SM attempted CPR and called 911. First responders arrived and transported the SC to the hospital. The MGM said the SC had a medical condition since birth and had stopped breathing in 2021. No additional details were documented.

An aunt reported that on 4/23/22, she left the infant cousin in the care of the MGM when she and the SM left the home around 10:00 PM. Around 10:00 AM on 4/24/22, the SM called her frantically saying the SC would not wake up. The aunt learned from the SM that around 9:30 AM, the children were running around, but the SC was not awake yet, so the SM checked on her, finding her unresponsive. The aunt reported the SC had medical conditions and surgeries and was not expected to live beyond 1 year; however, this information was not documented to have been further explored by ACS.

The 8-year-old sibling reported that on 4/23/22, he and the children played together, and the SC was fine. When he woke up on 4/24/22, the SC was asleep. The SM tried to wake the SC to no avail. The sibling observed the SM putting her hands on the SC's chest, but the SC did not wake up. ACS attempted to interview the sibling on another date; however, he did not want to talk about the incident, cried, and requested the interview to end. The 6-year-old cousin stated he did not remember the night prior to the death. The 4-year-old sibling did not communicate with ACS despite efforts to interview her.

On 4/24/22, ACS interviewed the SM alongside LE. The SM reported leaving the MGM's home around 11:00 PM and returned home around 1:00 AM on 4/24/22. The children were asleep at that time. The SC asked for a bottle during the night and was given some Pediasure. The SM went to the bathroom and when she returned, the SC was asleep. Around 10:00 AM, the SM checked on the SC and found her to be stiff and unresponsive. The SM brought the SC to the MGM and another aunt called 911. The operator instructed the SM to perform CPR until first responders arrived.

The other aunt reported she last saw the SC awake on 4/23/22 when she was dancing and playing. The aunt went to a friend's house around 9:00 AM on 4/24/22 and observed the SC on the couch. Around 10:00 AM, she returned to the home and saw the SM attempting to wake the SC and she called 911. She had no concerns for the care of the children.

ACS interviewed shelter staff where the SM and siblings resided. The shelter supervisor did not have concerns for the children and reported they were always supervised and did not have visible injuries. A hospital doctor reported the SC had pre-existing medical conditions; however, the record did not reflect whether ACS inquired if the pre-existing conditions could have played a role in the SC's death.

ACS offered the family bereavement services. The SM accepted the services. The SM utilized funeral assistance. The investigation remained open at the time this report was written.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS-approved Child Fatality Review Team in New York City.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061467 - Deceased Child, Female, 2 Yrs	061468 - Mother, Female, 37 Year(s)	DOA / Fatality	Pending
061467 - Deceased Child, Female, 2 Yrs	061468 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Pending
061467 - Deceased Child, Female, 2 Yrs	061469 - Grandparent, Female, 57 Year(s)	DOA / Fatality	Pending
061467 - Deceased Child, Female, 2 Yrs	061469 - Grandparent, Female, 57 Year(s)	Inadequate Guardianship	Pending
061467 - Deceased Child, Female, 2 Yrs	061472 - Aunt/Uncle, Female, 28 Year(s)	DOA / Fatality	Pending
061467 - Deceased Child, Female, 2 Yrs	061472 - Aunt/Uncle, Female, 28 Year(s)	Inadequate Guardianship	Pending

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?	☐	☒	☐	☐
Other	☐	☒	☐	☐
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)?	☐	☒	☐	☐

	Yes	No	N/A	Unable to Determine
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The record did not reflect attempts were made to interview the fathers. The record did not reflect ACS had yet to contact medical professionals regarding the child's preexisting condition and the possibility of it resulting in her death.

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?	☐	☒	☐	☐
Explain as necessary: The children did not need to be removed as a result of the fatality.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
A child care voucher was provided to the mother regarding the 4-year-old surviving sibling as the mother planned to return to work.

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:
The record reflected the school counselor offered counseling services to the school-aged children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was offered bereavement counseling, funeral assistance and child care services. She accepted the services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/13/2022	Sibling, Male, 8 Years	Mother, Female, 36 Years	Educational Neglect	Far-Closed	Yes

Report Summary:
An SCR report alleged during the 2021-2022 academic year the 8-year-old sibling was absent from school 53 days. As a result, the sibling was failing. The mother was aware; however, failed to adequately address the sibling’s truancy or intervene. The situation was ongoing.

OCFS Review Results:
The case was initiated timely, and a CPS history check was documented. The source of the report was contacted. ACS explained the FAR process and completed the FLAG with the mother. The family was interviewed, and collateral contacts were made. The home was assessed. Services were offered to the family and a Preventive Services Case was opened to assist with academic and housing concerns. Written Notice of Existence and closure were not provided to all parents. There were no documented attempts to contact the fathers.

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

Issue:
FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible

Summary:
The record did not reflect attempts to contact the fathers of the children regarding the SCR report.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)

Action:

Family assessment response workers must work in partnership with the families participating in a family assessment response. Workers should be transparent with families regarding all actions that they take regarding the case. To the extent feasible, child protective service workers should include all family members in discussions, including children who are old enough to express opinions, as well

Issue:

FAR-Failure to Provide Notice of Report

Summary:

The record did not reflect the mother, or the fathers of the children were provided with written notice of the SCR report.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:

No later than seven days after receipt of a child protective report that has been assigned to the Family Assessment Response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Issue:

FAR-Failure to Provide Notice of FAR Closure

Summary:

Although the mother was provided with written Notice of FAR closure, the record did not reflect the fathers were provided with written notice.

Legal Reference:

18 NYCRR 432.13 (e)(2)(viii)

Action:

No more than seven days after closing a FAR case record, the child protective service must notify the family, including all subject(s) of the report, that the case has been closed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/29/2021	Sibling, Male, 7 Years	Mother, Female, 36 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Male, 7 Years	Mother, Female, 36 Years	Lack of Supervision	Far-Closed	

Report Summary:

An SCR report alleged on 6/29/21, the then 7-year-old sibling woke up and began to fry chicken. The sibling burned the food, and smoke engulfed the entire shelter unit. At the time of the incident, the mother was asleep and failed to provide adequate supervision to the sibling.

OCFS Review Results:

The source of the report was contacted, a home visit was made, and the mother and sibling were interviewed. A CPS history check was documented. FAR was explained to the mother and the case was appropriately tracked FAR. The FLAG was completed with the family and collateral contacts were made. Safety Assessments were completed timely. Notice of FAR nor Notice of FAR closure were provided.

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

Issue:

FAR-Failure to Provide Notice of FAR Closure

Summary:

The record did not reflect the mother or fathers were provided with written Notice of FAR closure.

Legal Reference:
18 NYCRR 432.13 (e)(2)(viii)
Action:
No more than seven days after closing a FAR case record, the child protective service must notify the family, including all subject(s) of the report, that the case has been closed.

Issue:
FAR-Failure to Provide Notice of Report
Summary:
The record did not reflect written notice of FAR was provided to the adults.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
No later than seven days after receipt of a child protective report that has been assigned to the Family Assessment Response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

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

03/39/18- 10/17/18 The SM was unsubstantiated for Inadequate Guardianship of the 8yo SS.

3/11/19 - 5/31/19 There was an allegation of Inadequate Guardianship against the mother regarding the siblings. The case was tracked FAR.

Known CPS History Outside of NYS

There was 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