NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-022 **Prepared by: New York City Regional Office**

Issue Date: 9/21/2015

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
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
CPR-Cardio-pulmonary Resuscitation		
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	MN-Medical Neglect	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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Manhattan
Gender: Male
Date of Death: 03/20/2015
Initial Date OCFS Notified: 03/20/2015

Presenting Information

The report alleged that on 3/20/15, at approximately 7:11 AM the two-year-old child got up to use the bathroom and fell to the floor outside the bathroom. The child was not talking and he began to moan. The mother heard the child fall, she picked up the child and put him back to bed; checking on him periodically. Between 9:00 AM and 9:30 AM, the grandmother's home health aide (HHA) came into the home and began to administer CPR to the child along with an aunt due to the child being unresponsive. EMS was not contacted until about 10:30 AM. Also living in the home was the mother's paramour, grandfather, eight-year-old and three-month-old female children. The report alleged the adults failed to seek prompt medical attention for the child, thereby contributing to his death.

Executive Summary

The two-year-old male child died on 3/20/15. The allegations of the 3/20/15 report were DOA/Fatality and MN of the two-year-old child by the mother, mother's paramour (MP), MGM, and grandfather. As of 9/18/15, NYCRO has not yet received the ME's report.

The investigation was initiated on 3/20/15. The mother and her paramour's accounts differed. According to the mother, the child fell when she put him down to open the bathroom door. The child did not seem to hit his head but rather his back and buttocks. The mother said she placed him on the toilet and he leaned on the sink next to the toilet. The mother said she took him to the room and laid him on a pillow on the bed. The child's eyes were open; however, later she noticed there was a little blood on his crib sheet. The mother said she checked him two minutes later, did some chores then checked him again. The mother said the child appeared fine; however, later the child was not breathing and unresponsive. She called the MGM and told her the child was not breathing. The mother's cousin and the MGM's home health aide (HHA) performed CPR. Police and EMS arrived a short time later.

According to the MP, the child went to use the bathroom and he collapsed between the wall and the bathroom. The MP said he and the mother went to check the child; the mother picked him up and the child said he was fine. The MP said the child dozed off while he was sitting on the toilet. The mother took the child into the bedroom. The MP said initially he heard the child say he was fine, and later he heard the child say he was tired. The MP said the child fell hard and they were able to hear when he fell. The MP said the mother checked the child every five minutes and after three checks the mother yelled out. The MP said he attempted CPR and shortly thereafter, the MGM, mother's cousin, and HHA went into the home. The cousin maintained contact with EMS. The MP admitted to smoking marijuana prior to the child falling, but stated that he went into the hallway to smoke. The MP acknowledged that he was "high." The mother denied alcohol or drug use.

On 3/23/15, ACS filed an Article Ten Petition of Neglect naming the mother and MP as respondents. A remand was granted for the three-month-old surviving sibling who was then placed with the MGM via kinship foster care. The Catholic Guardian Society was the assigned foster care agency. The eight-year-old half sibling was paroled with ACS supervision to the MGM as she had custody of her prior to the child's death. The mother was granted supervised visits with the children and the father of the three-month-old was granted only supervised visits currently as he was the alleged father, not the legal father.

The ME informed ACS staff that the child had multiple injuries that could be a result of resuscitation attempts or could have been inflicted. The child had injuries to the head but none that would be life threatening. Later, the ME noted the child had intra-abdominal injuries. The ME explained that the abdominal injuries could have been caused as a result of multiple people, performing CPR for a very long time.

The 24-Hr Safety assessment was not completed in a timely manner as it was not completed until 3/25/15.

As of 9/18/15, no determination made.

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?** No
  - **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
NA

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:
The case was opened for services as the surviving half siblings were paroled and/or placed in kinship foster care with the MGM.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	ACS' documentation reflected that there were notes not entered contemporaneously. For example, an

	event occurred on 3/23/15 but was not entered until 6/23/15.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	ACS' documentation of the 30-Day Child Fatality Summary Report reflected that the Summary of Past Service History was not adequately completed.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/20/2015 **Time of Death:** 11:46 AM

Time of fatal incident, if different than time of death: 10:00 AM

County where fatality incident occurred: MANHATTAN
Was 911 or local emergency number called? Yes
Time of Call: 10:58 AM
Did EMS to 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:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:

Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Other	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Month(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	60 Year(s)
Other Household 1	Sibling	No Role	Female	8 Year(s)
Other Household 2	Grandparent	Alleged Perpetrator	Male	63 Year(s)

LDSS Response

The social worker (SW) obtained information from the mother regarding what occurred. According to the mother, the child awoke at about 7:00 AM to use the bathroom and fell. The mother and MP checked on him. The mother saw blood on his shirt. The child was drowsy and the mother put him on the toilet. His head was drooping and he was talking but not making sense. She put him back to bed and checked him every 15 minutes. The mother found the child unresponsive at 10:00 AM. The mother called the MGM at about 10:00 AM as the child was not responding. The MGM was not initially at home and returned home at about 10:30 AM. The MGM's HHA came to the home about five to ten minutes later. The family called EMS. The family attempted CPR by phone instructions being provided by EMS.

On 3/23/15, a subsequent report was registered with allegations of IG of the child and three-month-old sibling by the mother. The reports were investigated simultaneously.

The interview with the Dr. revealed that the mother reported the child was talking normally after falling. The mother said she put him back in the crib and he was talking and breathing well. The child stayed awake and she checked him every 15 minutes. The mother later found blood on the crib sheet when she picked him up at 7:00 AM. There was no sign of head injury and no suspicion of abuse. There was a concern that there was a delay in the family getting medical attention.

The MGM informed ACS that at about 10:30 AM the mother called stating that the child was not breathing. She went to the mother’s home; when she arrived, the child was lying on a mattress on the floor. The mother’s cousin and HHA went to the home and they gave CPR until EMS arrived. The MGM did not have concerns regarding the mother’s care for the children although the mother had a medical condition as a child which affected her cognitive development. The mother received services from a Community Based Organization.

The MGF said he was not a caretaker for any of the children.

The eight-year-old half sibling was in school when the incident occurred. The mother’s cousin said she overheard the MGM asking for assistance with contacting 911. ACS' documentation of the interview did not reflect the time the cousin heard the mother ask for assistance. At about 10:40 AM she went to the mother’s home with a phone and when she arrived the child was in bed in the living room. The cousin said she tried to perform CPR as the 911 operator was giving her instructions.

The HHA said she and the MGM returned to the MGM's home about 10:00 AM. The MP performed CPR. She also tried to perform CPR but the child did not respond.

In the interviews with the mother and the MP, the MP indicated he was "high" while the mother denied drug use.

LE said the mother stated the child was sleeping in the living room. She had the child in her arms and then put him down before entering the bathroom. The child fell before entering the bathroom. She checked the child every couple of minutes. He seemed fine at first but when she checked him the last time and she realized he was not breathing, she called the MGM.

On 3/23/15, ACS filed an Article Ten Neglect petition naming the mother and her paramour as respondents.

The ME informed ACS that the child had multiple injuries that could have been a result of resuscitation attempts or could have been inflicted. The child had injuries to the head but none that would be life threatening. The ME said there was no bleeding in the brain and no brain injury.

According to the EMS Liaison, calls were received at 10:58 AM, and 10:59 AM, and there were two separate calls at 11:02 AM.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The fatality investigation adhered to previously approved protocols for joint investigations.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
019021 - Deceased Child, Male, 2 Yrs	019022 - Mother, Female, 29 Year(s)	DOA / Fatality	Pending
019021 - Deceased Child, Male, 2 Yrs	019022 - Mother, Female, 29 Year(s)	Lack of Medical Care	Pending
019021 - Deceased Child, Male, 2 Yrs	019074 - Grandparent, Male, 63 Year(s)	DOA / Fatality	Pending

019021 - Deceased Child, Male, 2 Yrs	019074 - Grandparent, Male, 63 Year(s)	Lack of Medical Care	Pending
019021 - Deceased Child, Male, 2 Yrs	019070 - Other - Mother's Paramour, Male, 23 Year(s)	DOA / Fatality	Pending
019021 - Deceased Child, Male, 2 Yrs	019070 - Other - Mother's Paramour, Male, 23 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:

The ACS Investigation Progress Notes reflected that an event occurred on 3/23/15 but was not entered until 6/23/15. The 24 hour safety assessment was completed four days late. The seven day safety assessment was completed three days late.

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 safety 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 and placed in foster care at any time during this fatality investigation?	☒	☐	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
An Article Ten Petition was filed naming the mother and her paramour as respondents. The eight-year-old half sibling and three-month-old sibling are in the custody of the MGM. The eight-year-old child was paroled to the MGM as she

had custody of the child prior to the child's death. The three-month-old child was placed with the MGM through kinship foster care. Catholic Guardian Society was the assigned foster care agency.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/23/2015	There was not a fact finding	There was not a disposition
Respondent:	019022 Mother Female 29 Year(s)	
Comments:	ACS filed an Article Ten Neglect petition naming the mother and her paramour as respondents regarding the two surviving half siblings. A remand was granted for the three-month-old child and the eight-year-old child was paroled with ACS supervision to the MGM.	

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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: Community Based Organization

Additional information, if necessary:
The service plan reflected that both the mother's paramour and the father of the child were to be referred for substance abuse treatment. They both refused to comply with services. The three-month-old child was to be referred for Early Intervention. The parents of the child would be referred for evaluations and parenting classes. Referrals would be made to the Community Based Organization.

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 eight-year-old half sibling was paroled to the MGM. The three-month-old child was placed into kinship foster care with the MGM. The three-month-old child was referred for Early Intervention.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS' documentation reflected that the service plan included family members to be referred for bereavement counseling. The three-month-old child would be referred for Early Intervention. The parents of the two-year-old and three-month-old child would be referred for evaluations and parenting classes. The MP and the father of the two-year-old and three-month-old child would be referred for substance abuse treatment.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? 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)
11/11/2013	4132 - Deceased Child on Report, Male, 1 Years	4134 - Father, Male, 32 Years	Inadequate Guardianship	Indicated	Yes

Report Summary:
The father recently physically assaulted the mother after a verbal argument escalated. The father twisted the mother's arm behind her back while she was holding the then one-year-old child (now deceased) in her other arm. The father then punched the mother in the right ear, causing her to bleed. There were no injuries to the child.

Determination: Indicated **Date of Determination:** 01/10/2014

Basis for Determination:
The father physically assaulted the mother while she held the child placing him in danger of impairment. As a result the father was arrested. The Specialist found credible evidence to support that the father placed the child in danger of impairment by not providing adequate care of the child.

OCFS Review Results:
The investigation was initiated in a timely manner. The Seven Day Safety Assessment was inadequate as it reflected the safety factor the parent/caretaker was unable and/or unwilling to provide adequate supervision of the child was selected but the comments did not support this safety factor. The Investigation Conclusion Narrative (ICN) reflected that it was not adequate as it did not fully explain the determination. In the RAP ACS documented that the mother did not have limited cognitive skills; however, during a 2008 investigation, it was established that the mother dhad limited cognitive skills.

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

Issue:
Adequacy of case recording
Summary:
The Investigation Conclusion Narrative (ICN) did not fully explain the determination.
Legal Reference:
18 NYCRR 428.5(c)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The Seven Day Safety Assessment for the 11/11/13 report reflected the safety factor the parent/caretaker was unable and/or unwilling to provide adequate supervision of the child was selected but the comment documented did not support this safety factor. The Safety Assessment was not completed until 11/19/13.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed. OCFS is available to provide

technical assistance (TA).

Issue:
Review of CPS History
Summary:
The RAP documented that the mother did not have limited cognitive skills. However, during a 2008 investigation, the RAP reflected the mother had very limited cognitive skills.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS' documentation did not reflect that the MGM was interviewed regarding the exploration of the mother's cognitive ability nor the reason for her having custody of the mother's now eight-year-old child.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
The investigation was allegation focused. Although the mother was not a subject of the report, ACS should have obtained additional information regarding the family functioning and fully explore her ability to care for the child.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

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

The mother, maternal grandmother and grandfather were not known to the SCR or ACS as a subjects of a report. Also, the mother’s paramour was not known as the subject of a report.

The now eight-year-old half sibling was known as a confirmed maltreated child in one report dated 1/19/08. The allegation of the report was IG by the father. ACS investigated the report and substantiated the allegation of IG on 3/26/08.

The 11/11/13 investigation reflected the MGM had custody of the now eight-year-old half sibling since 2/2/10. The Specialist observed the custody documentation. The MGM was a foster parent.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?
☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	The father of the two-year-old child and the three-month-old child filed for visitation in March 2015 in Manhattan Family Court as he had not seen the children in three weeks. When he relocated out of the mother's home he was able to see the children regularly; however, since such time the mother would	

	not permit him to see the children. He had a court dated scheduled for 5/12/15. Later, documentation reflected that DNA testing determined he was not the father of the three-month-old infant.

Have any Orders of Protection been issued? Yes	
From: 11/12/2013	**To:** 05/11/2014

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