Child Fatality Report

Report Identification Number: NY-16-101

Prepared by: New York City Regional Office

Issue Date: Mar 24, 2017

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	

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	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-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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Not Found
Age: Unknown
Jurisdiction: New York
Gender: Unknown
Date of Death: Unknown
Initial Date OCFS Notified: 09/22/2016

Presenting Information

The 9/22/16 SCR report alleged that on an unknown date, the child (name unknown) ingested a battery and died as a result. The report also alleged at the time, the child was in the care of the SM. In September 2016, the SM gave birth to a male infant. The SM did not have adequate provisions for the newborn male infant or a place to live for her and newborn infant. The BF had an unknown role.

Executive Summary

This unidentified child was approximately 1-year-old at the alleged time of death on 1/1/16. According to the ME, there was no autopsy performed and no autopsy report for the case. Neither the ME or LE established the child referenced in the SCR report had died. LE officials said the police investigation closed on 9/28/16.

The allegations of the 9/22/16 report were DOA/Fatality and IG of a child (listed as unknown) and IF/C/S and IG of a surviving newborn male infant (referred to as the SC) by the SM. The family history did not reveal the SM had a child of the approximate age suggested in the 9/22/16 report. The SM had a criminal record and child welfare history in NJ and Florida. The SM had a 13-year-old male child who reportedly resided with relatives in Florida. The SM's parental rights were allegedly terminated for her 10-year-old male child who resided in New Jersey with the MA. An Article Ten Neglect petition was filed in New York County Family Court (NYCFC), on behalf of the SM's 2-year-old male child, on 5/19/14. The 2-year-old child was in the care and custody of the Commissioner of ACS and remains in foster care with Catholic Guardian Society (CGS) agency.

The Mt. Sinai Hospital staff informed ACS that the SC was born at approximately 27-weeks gestation in September 2016. The SM tested positive for illicit substances at the time of hospital admission on 9/18/16. During the Mt. Sinai Hospital visit on 9/22/16, the SM told ACS staff that she was recently released from Riker's Island for an unrelated incident. The SM denied her child died due to swallowing a battery. ACS documented, SM told hospital staff about her loss of a child in utero and the medical care she received in Harlem Hospital . ACS received the SM's Harlem Hospital medical records on 9/28/16. The records did not reflect the SM had a child who died in utero. The records showed the SM walked into the ER and complained of unspecified intoxication, on 1/19/16. The SM also informed ACS she was homeless. ACS noted the SM was interested in enrolling in an in-patient program. The SM said her three older children were not in her care. During a hospital visit ACS observed the SC in the neo-natal intensive care unit (NICU). SC was expected to remain in the hospital for several months to receive medical care. ACS monitored the SC and verified he was receiving medical care. The Dr. referred the SM to the clinic outpatient detoxification unit. The SM did not have ER visits, prior to 1/19/16.

ACS convened an Initial Child Safety Conferences (ICSC) on 10/3/16. The SM did not attend the ICSC. ACS learned Mt. Sinai Hospital offered the SM detoxification services, however, the SM refused services. ACS added the SC to the existing Article Ten petition, naming the SM as the respondent. The SC was remanded to the care and custody of the Commissioner of ACS on 10/3/16. ACS recommended substance use treatment, employment and other services for the SM and Early Intervention services for SC. ACS documented that SM was homeless and a home visit was not conducted. On 10/13/16, the Assistant District Attorney informed ACS that the SM was arrested on 10/12/16 and charged with possession of cocaine.

ACS mailed a notification letter to the BF at the address provided by the Family Court Legal Services attorney. ACS made attempted phone contacts to the MA on 11/30/16, 12/02/16 and 12/13/16; no additional efforts to contact the SM or MA via mail notification was documented in record. The CGS agency case planner (CP) conducted an inmate search but was unable to obtain information about the SM. The SC was placed in the foster home with his 2-year-old-male sibling on 12/6/16. The CP observed the 2-year-old child and newborn infant in the foster home on 12/12/16. The CP observed the sleeping arrangements which were satisfactory and discussed Early Intervention/ health care needs. On 1/22/16, ACS unfounded DOA/FAT and indicated PD/AM against the SM.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
N/A

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:
ACS did not make diligent efforts to locate the SM and BF.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Child Protective Services casework contacts
Summary:	ACS did not obtain official records to verify the whereabouts of the mother's two older children who were approximately 10 years old and 13 years old, respectively.
Legal Reference:	432.2(b)(4)(vi)
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 did not complete the required 30-day report in as timely manner. ACS completed the 30- day fatality report on 11/3/16.
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 staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	ACS did not complete the 30-day child fatality safety assessment within the required timeframe.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(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 staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	ACS did not enter progress notes contemporaneously. There were large gaps between the event and the entering of Progress Notes.
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 staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Adequacy of case recording in FASP
Summary:	FASP progress notes lists two unknown children not listed within the investigation. CP agency lists an older daughter and an older son that lives in NJ. CP did not mention D.O.B. and names of children.
Legal Reference:	18 NYCRR 428.6(a)
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 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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim		
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Month(s)
Other Household 1	Sibling	No Role	Male	2 Year(s)

LDSS Response

On 9/22/16 ACS staff responded to information about the child fatality by initiating an Instant Response Team response. ACS reviewed family history, obtained information from relevant hospital contacts and found the SM did not have a child of the approximate age as alleged in the 9/22/16 report. The Medical Examiner's Office conducted a search and did not locate any child that died for the SM.

On 9/22/16, ACS made face-to-face contact with the SM, attending Dr., and nurse in the hospital. ACS learned the SM went to the hospital on 9/18/16. The SM was admitted in the hospital and she tested positive for cocaine and opiates. She admitted she used heroin on 9/17/16. ACS documented the SM denied reports of a deceased child and admitted to having two other male children, who were not in her care. The nurse informed ACS that the new born male infant would remain in the hospital until he was fully developed and would be closely monitored.

On 9/27/16 ACS made telephone contact with LE; notification was given to ACS that the case would be closed because there was no deceased child.

ACS learned on 9/28/16 that the SM was seen at Harlem Hospital on 1/19/16 for an unrelated issue. ACS documented phone contact with CGS in efforts to ascertain the whereabouts of the 2-year-old male child. ACS confirmed the 2-year-old child was in foster care with CGS.

On 9/28/16, ACS was notified by the hospital that SM left, without discharge orders. ACS held a Child Safety Conference on 10/3/16; the SM was not in attendance. ACS determined it was necessary to seek a remand and removal of new born infant. ACS recommended providing substance abuse treatment, mental health, housing/income assistance for SM, and medical and Early Intervention services for newborn infant.

On 10/3/16, ACS consulted with Family Court Legal Services (FCLS) and filed an Article Ten petition on behalf of the newborn infant. ACS documented SM was not in attendance because she was incarcerated for possession of drugs.

ACS documented the agency sent correspondence sent to the ME on 11/3/16 to inquire about case. On 11/9/16 ACS contacted the hospital to inquire about the progress of infant male. ACS was notified that the infant male was not ready for discharge.

On 11/14/16 and 11/30/16, ACS attempted collateral phone contact with the MA. ACS forwarded written notification to FCLS to obtain address of the infant's BF. According to the ACS case record the BF was served, by mail, notice of the petition and Notification of Existence of the SCR report.

ACS monitored the newborn infant's medical care until he was discharged from the hospital and placed in the foster home with his 2-year-old sibling. In an Investigation Progress Note dated 12/16/16, ACS staff noted that a transition meeting

with CGS occurred. ACS staff discussed the service plan for the SM, 2-year-old and newborn SC. ACS noted that the SM's whereabouts were unknown.

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
031902 - Deceased Child, ,	035864 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
031902 - Deceased Child, ,	035864 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
035866 - Sibling, Male, 2 Month(s)	035864 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
035866 - Sibling, Male, 2 Month(s)	035864 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
035866 - Sibling, Male, 2 Month(s)	035864 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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:
ACS did not make diligent efforts to interview family members.

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?	☒	☐	☐	☐
Explain: ACS 30-day safety Assessment was not completed in a timely manner.				

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
ACS filed an Article Ten Neglect petition in New York County Family Court on 10-03-16 and the SC was remanded to ACS.

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:**
10/03/2016	There was not a fact finding	There was not a disposition
Respondent:	031922 Mother Female 28 Year(s)	
Comments:	On 10/03/16, ACS filed an Article Ten Neglect petition on behalf of SC. The SM did not appear. The SC was remanded to ACS and placed with the Catholic Guardian Services foster care agency.	

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The family received foster care services. The SM's whereabouts were unknown.

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:
ACS filed an Article Ten Neglect in New York County Family Court on behalf of the newborn infant naming the SM as the respondent. The newborn infant was remanded to the care and custody of the Commissioner of ACS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The SM did not cooperate with the service plan requirements.

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)
04/24/2014	11723 - Sibling, Male, 1 Days	11722 - Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Indicated	Yes

	11723 - Sibling, Male, 1 Days	11722 - Mother, Female, 25 Years	Inadequate Guardianship	Indicated

Report Summary:
The 4/24/14 report alleged the SM had been on medications throughout her pregnancy. The newborn male infant tested positive for methadone. SM's mental health issues precluded her ability to provide adequate care to the newborn infant.

Determination: Indicated **Date of Determination:** 06/05/2014

Basis for Determination:
ACS substantiated the allegations of IG and PD/AM of the SC by the SM on the basis that the ACS staff observed the SM failed to provide a minimum degree of care for SC. The SM received daily methadone maintenance which had affected her alertness and motor skills. The ACS staff had observed appearing over sedated to the point of sluggishness, tired and unable to keep eyes open. SM failed to comply with treatment plan. ACS also gathered evidence from collaterals who observed SM falling asleep while holding SC. The SM's toxicology reports were positive in February, March, and April 2014.

OCFS Review Results:
ACS found BM had two older male children who were allegedly in New Jersey and Florida. ACS failed to document contact with two male children and caretakers. The investigation was inadequate as the agency did not obtain information from relevant collateral contacts. ACS documented the family has no prior child welfare history; however, the Investigation Progress Note dated 4/25/14 indicated the SM and family had prior history in New Jersey and Florida. ACS held an Initial Child Safety Conference (ICSC) on 5/19/14 and did not document the outcome of the medical consult and ICSC. ACS did not follow-up with LE regarding SM's child welfare related criminal history charges.

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

Issue:
Adequacy of case recording
Summary:
ACS did not document the 4/25/14 Investigation Progress Note within the required 30-day timeframe. The event date was listed as 6/9/14.
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:
Diligence of Efforts
Summary:
ACS did not conduct diligent efforts to locate the SM's two older children.
Legal Reference:
NYCRR 430.12D
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:
Face-to-Face Interview (Subject/Family)
Summary:

ACS did not attempt to make a face-to-face contact to interview the BF.

Legal Reference:

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

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 did not document information from relevant collateral contact, including the medical consultant, maternal relatives. ACS documented in 4-25-14 progress note, SM's support systems was MGF and MA.

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:

Timeliness of completion of FASP

Summary:

ACS did not complete the FASP timely. The FASP due date was 6/8/14 (the approval date was documented as 6-10-14.

Legal Reference:

18 NYCRR 428.3(f)(5)

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:

Adequacy of Progress Notes

Summary:

ACS documented in a 4-25-14 Investigation Progress Note that the SM has prior history in New Jersey and Florida. ACS supervisor also documented in 4/25/14 progress note that there was no prior history, in regards to SM. CPS documented in progress note dated 4/28/14 that family had no prior history.

Legal Reference:

18 NYCRR 428.5

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:

Adequacy of Child Protective Services casework contacts

Summary:

ACS did not document Collateral contact with Medical Consult. ACS did not contact SM's, MGF and maternal sisters. ACS documented in 4-25-14 progress note, SM's support systems is MGF and Maternal sisters.

Legal Reference:
432.2(b)(4)(vi)
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.

[redacted]

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

There was no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

The SM was known to CPS in Florida and New Jersey. The SM had history in Florida concerning parent's drug misuse related to her child in 2007. According to the New Jersey Division of Youth and Family Services, the SM's two older children were removed from her care due to neglect. At the time of ACS involvement, the two older children were no longer in the SM's care and custody.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened:

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.

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