Child Fatality Report

Report Identification Number: NY-16-120

Prepared by: New York City Regional Office

Issue Date: May 30, 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 Deceased
Age: 0 day(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 11/19/2016
Initial Date OCFS Notified: 11/19/2016

Presenting Information

The 11/19/16 SCR reported alleged, the SM gave birth to SC in the home at approximately 5:00 PM. The MGF was in the home at the time of the SC's birth. The MGGM returned home shortly after the SC was born. The SC was breathing at the time of birth. The SM, MGF, and MGGM delayed in seeking medical treatment for the SC, waiting an hour before calling 911. At the time the family called 911, the SC had stopped breathing. The SC was pronounced dead upon arrival to the hospital. The cause of death was unknown. The MA was at work at the time of this incident. The roles of the MA and a 14-year-old female child were unknown.

Executive Summary

This 1-day-old female SC died on 11/19/16. According to the ME there were no injuries or bruises observed on the SC and the autopsy results were pending further studies. As of 5/30/17, NYCRO has not yet received the autopsy report.

The allegations of the 11/19/16 report were DOA/Fatality and IG of the SC by the SM, MGF and MGGM.

On 11/19/16, ACS interviewed the SM regarding the circumstances surrounding the death of the SC. According to the SM, on 11/19/16 at approximately 4:00 PM she experienced severe abdominal discomfort and began the process of childbirth. The SM said she texted the MGGM at 4:54 PM to inform her she was giving birth and requested guidance. The SM told the MGGM not to inform the MGF. The MGGM told the SM to call 911. The SM called 911, and the operator guided the SM throughout the birthing process. The SM said the SC was born alive and cried. The SM requested the assistance of the minor MA, to help cut the umbilical cord. The SM stated at some point the SC stopped breathing and the SM performed CPR on the SC. The SM proceeded to await EMS' arrival outside the home. The MGGM arrived at the case address at the same time as EMS. The MGGM observed the SM was holding the SC outside. The SM observed a second ambulance arrived shortly after the MGGM's arrival. The SM and SC were taken to the Jacobi Hospital where the SC was pronounced dead.

The SM explained prior to the death of the SC, she was unaware she was pregnant and had not received prenatal care. The SM said during her last physical exam on 7/27/16, the Dr. prescribed her medication; which she took as prescribed.

It was unclear what time the SC was born, what time the SC stopped breathing and if EMS operator instructed the SM to cut the SC's umbilical cord without informing the SM of the dangers of not clamping the umbilical cord. The SM stated this was her first pregnancy and continued to state she did not know she was pregnant. The SM did not know she was pregnant, therefore she did not receive prenatal care.

According to the ACS case record, the SC was delivered in a 3-bedroom apartment where the SM resided with the MGF, MGGM, MA and minor MA. During the home visit, ACS observed the home was cluttered, in disarray and with no obvious odor. There were insects and a dead mouse on a trap observed in the kitchen. There appeared to be an adequate supply of provisions in the home. The SM and the minor MA shared a cluttered sleeping space in the living room. The SM and minor MA slept on separate twin sized beds. The SM's bed was visibly damaged as a result

of the birthing process. There were old and current electronics and piles of garbage bags observed throughout the apartment. To the back of the home were the bedrooms of the MGF, MGGM, MA and a bathroom. The rooms of the MGGM and MGF were not observed. The MGGM's room door was closed and the MGF's room contained the family's dog. ACS observed installed window guards; however, there was no working smoke/carbon monoxide detector in the home.

The family accepted the ACS offer for preventive services. ACS provided the SM with a replacement twin bed, a mental health referral, burial assistance and a working smoke/carbon monoxide detector. On 12/28/16, ACS opened the Family Services Stage (FSS) and the family was referred for PPRS. On 2/8/17, ACS conducted a joint home visit with the Leake and Watts Services agency CW. ACS staff and the PPRS CW discussed services with the family. The family agreed to participate in therapy services and educational opportunities.

On 5/29/17, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the SM on the bases there was some credible evidence the physical condition of the SC was impaired as the SM did not clamp the SC's cord. The SM failed to exercise a minimum degree of care in supplying adequate medical care when the SM gave birth to the SC. ACS unsubstantiated all allegations by the MGF and MGGM as they were unaware the SM was pregnant.

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?** Yes

Determination:

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

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:
The determination made by ACS to indicate the report was appropriate. There were no surviving siblings.

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: 11/19/2016 **Time of Death:** 06:52 PM

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

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: 06:11 PM
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: birthing process

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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Hour(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	65 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	17 Year(s)
Deceased Child's Household	Other Child	No Role	Female	14 Year(s)
Other Household 1	Father	No Role	Male	16 Year(s)

LDSS Response

According to LE, the MGF and 14-year-old MA were in the home at the time of the incident; however, neither were aware that the SM was pregnant. LE said the living environment was in a deplorable condition and household cleaning supplies were observed. LE obtained text message exchanges between the SM and MGGM dated 11/19/16. The SM texted the MGGM around 5:44 PM to inform her that the SC was coming out and asked what should she do. The MGGM returned

the SM's text message and told her to call 911. There were no arrests made.

On 11/19/16, the attending Dr. said the SC was born full term at approximately 37 weeks. The SC arrived at the hospital with no blood on the body. The SC's umbilical cord was cut and the SC "bled out" through the umbilical cord. The death did not appear to be suspicious. The Dr. said when EMS arrived at the home, the SC was dead; therefore, a time of death could not be determined.

According to the ME, no visible injuries or bruises were found on the SC's body. The ME had gone to the home to retrieve the placenta and to obtain additional information about the birth of the SC.

On 11/20/16, ACS attempted to conduct a home assessment; however, LE deemed the home a crime scene and ACS was not allowed to enter.

According to the MGGM, the family had recently gone on a vacation. The SM did not appear to be pregnant. The day of the incident, the MGGM went to church and the MGF went to work. The SM sent MGGM a text around 5:20 PM and said she needed to go to the hospital; however, the SM did not indicated the reason for the request.

According to the MGF, he was unaware of the SM's pregnancy until after the SM had given birth. The MGF appeared visibly shocked and in disbelief. The MGF said the SM and MA, had lived in the home with him and the MGGM for approximately 18 months. The SM and MA had resided out of state with the MGM. The MGF said the MGGM went to retrieve the SM, MA along with the adult MA. The MGF returned home from work around 5:00 PM and observed the SM and MA were on their beds in the living room; the SM was laying under the covers and the MA was sitting on her bed. When asked by the MGM, both the SM and MA responded they were fine. Shortly after, the MA entered the MGF's room to tell him, she and the SM had to meet the MGGM downstairs. About 10 minutes later, he called the MGGM and he learned the MGGM was at the hospital with the SM and MA; as the SM gave birth to SC in the home. The MGF said the household cleaning supplies were kept near the front door. The products were frequently used to clean up after the family dog, which the MGF did shortly before LE arrived.

The Specialist interviewed the identified BF of the SC. He said the SM and he attended the same school and were dating. However, since his transfer to another school; they were no longer in a relationship. The BF said he was unaware of the SM's pregnancy.

On 11/23/16, the medical Dr. said the SM's initial visit to the medical office was on 9/14/2015. The SM's recent medical exam was on 7/21/16. The SM made an office visit on 7/27/16 and medication was prescribed. The staff confirmed no pregnancy test was administered to the SM.

On 1/18/17, the MGM said she did not know the SM was pregnant. The MGM stated when the SM was in her care, the SM engaged in delinquent and violence behavior; however, since living in NY with the MGF and MGGM; the SM's behavior had significantly improved.

On 2/8/17, ACS conducted a joint home visit with the PPRS agency. ACS and the PPRS CW discussed a service plan with the family. The family agreed to accept the service plan requirements.

On 3/6/17 and 4/24/17, the therapist conducted an in-home session where the family was engaged in the service. There were no safety concerns identified in the home at the time of the visit. The risk elements identified during the sessions were around the family's poor communication and problem solving skills.

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 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 OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
036361 - Deceased Child, Female, 1 Hour(s)	036064 - Grandparent, Female, 65 Year(s)	Inadequate Guardianship	Pending
036361 - Deceased Child, Female, 1 Hour(s)	036063 - Grandparent, Male, 40 Year(s)	DOA / Fatality	Pending
036361 - Deceased Child, Female, 1 Hour(s)	036063 - Grandparent, Male, 40 Year(s)	Inadequate Guardianship	Pending
036361 - Deceased Child, Female, 1 Hour(s)	036064 - Grandparent, Female, 65 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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)?	☒	☐	☐	☐
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 EMS liaison obtained the EMS run sheet and log. However, ACS did not make diligent efforts to contact the responding EMS unit.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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	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: Furniture assistance							

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? N/A
Explain:
There were no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM required immediate medical attention; therefore she was admitted to Jacobi Hospital.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:

☐ Drug exposed
☐ With fetal alcohol effects or syndrome
☒ With neither of the issues listed noted in case record

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)
11/19/2016	14911 - Mother, Female, 17 Years	14912 - Grandparent, Male, 40 Years	Inadequate Guardianship	Indicated	Yes
	14914 - Aunt/Uncle, Female, 14 Years	14912 - Grandparent, Male, 40 Years	Inadequate Guardianship	Indicated	
	14911 - Mother, Female, 17 Years	14913 - Grandparent, Female, 65 Years	Inadequate Guardianship	Indicated	
	14914 - Aunt/Uncle, Female, 14 Years	14913 - Grandparent, Female, 65 Years	Inadequate Guardianship	Indicated	
	14911 - Mother, Female, 17 Years	14913 - Grandparent, Female, 65 Years	Lack of Medical Care	Unfounded	
	14911 - Mother, Female, 17 Years	14912 - Grandparent, Male, 40 Years	Lack of Medical Care	Unfounded	

Report Summary:
The 11/19/16 SCR report alleged, the SM gave birth in the home to an infant. The MGGM and MGF were aware the SM had given birth in the home, but delayed in seeking medical treatment for the SM. The MGGM and MGF waited approximately one hour before calling 911; the reason for the delay was not noted. The conditions of the home posed a safety and health concern to the SM and minor MA. The home was dirty with kitchen trash all over the home. The home was invested with roaches.

Determination: Indicated | **Date of Determination:** 01/25/2017

Basis for Determination:
There was some credible evidence gathered to substantiate the allegation of IG of the SM and minor MA by the MGGM and MGF. Initially, the home conditions were inappropriate but improved shortly thereafter. The was no credible evidence gathered of LMC of SM by the MGGM and MGF. They denied having knowledge of the SM's pregnancy. The SM received routine medical care. The SM's medical doctor did not know the SM was pregnant.

OCFS Review Results:
ACS obtained and provided supporting documentation relevant to the investigation from LE, CPS and social service history databases and medical provider records.

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

Issue:
Failure to Provide Notice of Indication

Summary:
The CONNECTIONS record does not indicate that the subjects were provided a NOI.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/21/2014	14974 - Aunt/Uncle, Female, 16 Years	14973 - Grandparent, Female, 57 Years	Inadequate Food / Clothing / Shelter	Unfounded	No
	14975 - Mother, Female, 15 Years	14973 - Grandparent, Female, 57 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	14975 - Mother, Female, 15 Years	14973 - Grandparent, Female, 57 Years	Inadequate Guardianship	Unfounded	
	14974 - Aunt/Uncle, Female, 16 Years	14973 - Grandparent, Female, 57 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The MGGM had no food in the house for the SM and adult MA, ages 15 and 16 years old.

Determination: Unfounded | **Date of Determination:** 09/22/2014

Basis for Determination:
ACS unsubstantiated the allegations of ICFS and IG for lack of credible evidence. The CPS in the state of the SM residency interviewed the SM; who denied babysitting children and telling anyone the MGGM did not have food in the home while she was visiting the home during school break. The 16 year old adult MA; who resided with the MGGM denied the same. The Specialist observed food in the home during the investigation. During the investigation the adult MA appeared healthy and was attending school regularly.

OCFS Review Results:
ACS obtained and provided supporting documentation relevant to the investigation from LE, CPS and social service history databases and medical provider records.

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

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

The MGF was known as a subject in a 3/20/03 SCR report. On 5/19/03, ACS substantiated allegations of FX and IG by the MGF.

Between 2/11/09 and 1/16/13, the family was known in one unfounded report, three indicated reports and two suspended reports as duplicates of two indicated investigations. These reports were concerning the SM and minor MA. ACS addressed concerns related to the children's school attendance and the MGM's domestic dispute with her paramour. According to the ACS case record, the children's attendance improved and the MGM arranged for the PGM to escort the children to school to ensure they arrived on time. Regarding the 1/16/13 investigation, the documentation showed the family moved out of the jurisdiction.

Known CPS History Outside of NYS

The SM had no CPS history outside of NYS as a subject. The SM was listed as a subject child in two CPS investigations in Halifax County.

On 9/23/16- the allegations of PD/AM and IFCS of the SM, adult MA and minor MA by the MGM and her paramour were unsubstantiated due to the denial of the allegations by all family members. The family was found in need of medical

services and the county assisted the family with obtaining medical insurance.

On 4/13/15- the allegations of PD/AM, IFCS and IG. The outcome of the investigation was unclear. There was no determination documented in the ACS case record.

On 6/15/15- the SM and minor MA assaulted the MGM and her paramour in the school. The MGM would not allow the children to return to the home. The children were put into juvenile detention. On 6/18/15, the juvenile court released the children to the care of the MGGM; as she was willing to take both children and return to NYC.

Required Action(s)

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

Preventive Services History

On 4/26/12, the FSS stage of the case was opened and was closed on 4/27/12 after the MGM provided documents and letters to ACS confirming the MA and SM's enrollment in school.

On 1/14/10, ACS made a PPRS referral for the family to receive preventive monitoring, education and mental health services; however, the family was not accepted by an agency in their area of residence. ACS staff observed the children appeared healthy and had attended school regularly. There were no safety concerns observed. On 4/8/10, the family declined further services and the FSS was closed.

On 12/16/10, ACS made a PPRS referral for the family to receive preventive monitoring, mentoring, parenting and domestic violence services. ACS observed no safety issues during the two successful home visits that were conducted. The documentation revealed there was no contact with the family for six months. The family refused services. On 12/8/11, ACS closed the FSS stage with 12 Family Services Progress Notes entries. The reason ACS had no contact with the family for a six- month period during the stage was unclear.

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