Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-17-050

Prepared by: New York City Regional Office

Issue Date: Nov 20, 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	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 05/24/2017
Initial Date OCFS Notified: 05/24/2017

Presenting Information

The 5/24/17 SCR report alleged the 2-year-old SC was under the care of the PGM, PA and PU. The SC drank a bottle of milk and started to throw up for reasons unknown. Fifteen minutes later, the SC passed out. EMS was called to intervene and attempted CPR at the home. The SC was then taken to the hospital and later pronounced dead at 7:35 PM. As a result, the adults present in the home at the time were considered alleged subjects, due to the fact there was no plausible explanation for the SC's death. The roles of the PA's three children were unknown. The roles of the birth parents and an adult male cousin were unknown.

Executive Summary

This two-year-old female child died on 5/24/17. The family declined an autopsy due to their religious beliefs. According to the ME's report, there were no physical injuries observed during the of External Examination. The report did not indicate the cause and manner of death.

The SCR report included the allegations of DOA/Fatality and IG of the SC by the PGM, PA and PU.

ACS obtained the PA's statement regarding the death of the SC from LE as the PA declined to communicate with ACS. The PA explained she gave the SC a bottle of regular milk around 6:00 PM. The SC drank the bottle of milk and began to throw up for reasons unknown and then she passed out. The PU called 911 at approximately 6:48 PM and the PA called the BF, who was at the hospital with the BM. EMS arrived and attempted CPR on the SC at the home. Shortly thereafter, the BF returned to the home. Via ambulance, the SC and the BF were escorted to Coney Island Hospital. The PA, PU and the three minor cousins were escorted to the hospital by LE. EMS arrived at the hospital at approximately 7:08 PM where ER staff continued CPR. Other resuscitative measures were implemented; however, they were ineffective. The SC was pronounced dead at 7:35 PM.

The parents were not in the home at the time of the incident. The parents temporarily left the SC in the care of the PA due to the BM's hospitalization. The parents and SC resided with extended family members in a two-bedroom apartment. The Specialist observed working and in place smoke/carbon monoxide detector. The home was adequately furnished. ACS observed an adequate supply of provisions for the family. The subjects along with the minor cousins shared a room and the parents shared the second bedroom with the SC. Both rooms consisted of adequate sleeping arrangements and a crib for the newborn SS was observed in the parents' room.

During the investigation, ACS gathered pertinent information about the circumstances surrounding the SC's death by the account from the subjects and parents. ACS obtained supporting documentation from the ME, LE and social service history databases and medical provider records and ACS made collateral contacts with neighbors, medical and social service staff. All members of the household denied history of DV, MH and substance abuse.

On 5/25/17, 5/30/17, 5/31/17 and 6/27/17, ACS attempted to engage the BM and offered services; however, she declined participation and refused all communication with ACS. On 5/31/17, the BM, BF, PGM and PU attended the Child Safety Conference (CSC) at the ACS office. The family's participation in the CSC was minimally documented. ACS provided language interpretation services in the family's primary language for engagement and to address concerns, discuss and offer services. ACS monitored the case and noted that the PA gave birth to a male child in July 2017.

On 9/15/17, ACS unsubstantiated all the allegations of the 5/24/17 report on the basis of lack of credible evidence to support the DOA/Fatality and IG allegations. ACS explained that the BM and BF refused an autopsy for religious reasons and the ME ruled the SC's death was an undetermined natural cause.

As a result of a previous investigation involving the PA, ACS opened a FSS stage on 5/12/17 after the PA agreed to receive PPRS. A preventive services agency had not been assigned case planning responsibility at the time of the fatality. Following the SC's death, the FSS remained open, ACS assigned a voluntary agency to the case. On 10/6/17 a CP observed and engaged the cousins in the home. The cousins appeared free of scars and bruises. There were no safety concerns noted.

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?** 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?** 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:
N/A

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	ACS did not approve the 24-hour report within the required timeframe. The SCR report was dated 5/24/17. ACS approved the 24-Hour safety report document on 5/26/17.

Legal Reference:	CPS Program Manual, VIII, B.1, page 2
Action:	ACS must submit a PIP 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 24 Hour Assessment
Summary:	The SCR report was dated 5/24/17. ACS approved the 24-Hour safety assessment on 5/26/17. The safety assessment did not reflect ACS' assessment of the PA's children residing in the home.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a PIP 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:	The SCR report was dated 5/24/17. The 30-Day Fatality Report and the corresponding 30-Day safety assessment were approved on 7/12/17 and 7/19/17, respectively. Neither the report or the assessment were approved within the required timeframes.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must submit a PIP 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:	A progress note dated 5/30/17 stated the subject PGM was interviewed; however, the information gathered from the interview was not documented. The record did not include information obtained from the 6-year-old child who was in the home.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	ACS must submit a PIP 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:	ACS listed the caretakers' inability to supervise/protect and/or care for the children as a safety factor. An assessment of the PA's three children was essential to conduct a thorough assessment of safety.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a PIP 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:	Failure to provide safe sleep education/information

Child Fatality Report

Summary:	During the initial assessment of the newborn infant on 8/1/17, ACS did not provide the PA with safe sleep education or assessed if the PA had adequate sleeping arrangements for the newborn infant.
Legal Reference:	13-OCFS-ADM-02
Action:	ACS must submit a PIP 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: 05/24/2017 **Time of Death:** 07:35 PM

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: 06:48 PM
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:

- ☐ 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? No
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	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Father	No Role	Male	27 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	51 Year(s)
Deceased Child's Household	Mother	No Role	Female	28 Year(s)

Deceased Child's Household	Other Adult - Cousin	No Role	Male	29 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	11 Month(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	3 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Day(s)

LDSS Response

On 5/24/17, LE stated the home was deemed a crime scene and ACS was not allowed on the premises. LE stated the three minor cousins did not appear malnourished and had no marks or injuries. The cousins appeared happy or comfortable in the case address. The subjects and the cousins were escorted to Coney Island Hospital. No arrests were made.

According to the LE's interview of the PA, she prepared the SC a bottle of regular milk and this was the first time the SC vomited as result of drinking milk. The SC had no preexisting condition. The BM and BF were not home at the time of the incident as the BM was in Maimondes Hospital where she gave birth to the SS.

The Specialist visited Maimonides Hospital; however, the BM was discharged from the hospital. ACS observed the SS in the nursery for medical monitoring. The medical staff stated the SS was born full term and healthy.

On 5/24/17, the Specialist's efforts to contact the subjects and the parents to assess the remaining three minor cousins in the home for safety, were unsuccessful.

According to the ME, the BM and BF declined an autopsy; therefore, only an external examination and fluid samples were obtained for the toxicology. Upon the ME's physical examination of the SC's body, there was no sign of trauma observed. Other scans and testing by the ME revealed normal results. The toxicology results were pending.

On 5/25/17, the attending Dr. stated EMS arrived with the SC in cardiac arrest around 7:08 PM. The SC had no pulse, CPR was continued and emergency medication was administered in an attempt to resuscitate the SC; however, the efforts were unsuccessful. The Dr. stated the SC's head and body were of normal size, there were no observable signs of external injury. An x-ray of the SC's chest detected a malformation of the lung.

ACS made collateral contacts and found that the family and extended family members had been residing in the apartment building for short time. The family was described as pleasant. There were no concerns regarding the safety of the three minor cousins in home or the care they received by their parents.

On 5/26/17, the Specialist visited a relative's home to assess the three minor cousins for safety. During the visit, the PU did not allow ACS into the relative's home to interview the family or the minor cousins. The PU allowed ACS to observe the minor cousins' physical appearance. The cousins were observed to be appropriately dressed. They were free of marks and bruises on visible areas.

According to the PU, he was in the home the day of the SC's death until about 6:30 PM. The PU said he observed the SC awake and playful throughout the day. The PU stated the PA was caring for the SC as the BF was at work and the BM was in the hospital. The PU's statement of the incident was consistent with the statement the PA provided LE.

On 6/27/17, the Specialist assessed the SS and the cousins for safety. The children appeared clean, cared for and free from marks and bruises. ACS observed adequate provisions in the home. It was not documented if safe sleep education was discussed with the BM.

The PA gave birth to a male child in July 2017. On 8/1/17, the Specialist assessed the SS, cousins (the newborn cousin was observed in a car seat), and the SS was observed in a swing. The three cousins were playing in the home and they appeared healthy. ACS observed adequate provisions for the cousins; however, ACS did not assess whether the family had adequate sleeping arrangements of the PA's newborn child.

On 8/11/17, ACS and PPRS CP made a joint home visit as the PA agreed to accept services. The parents refused participation. The PA shared that the newborn cousin had slept in a car seat since birth. ACS counseled the PA on safe sleep practices and ordered a crib for the newborn cousin. The CP had not adequately assessed the newborn cousin's sleeping arrangement or provided safe sleep education during the 7/19/17, 7/24/17 and 8/8/17 home visits.

Official Manner and Cause of Death

Official Manner: Natural
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)?Yes
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
038261 - Deceased Child, Female, 2 Yrs	038267 - Grandparent, Female, 51 Year(s)	Inadequate Guardianship	Unsubstantiated
038261 - Deceased Child, Female, 2 Yrs	038265 - Aunt/Uncle, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
038261 - Deceased Child, Female, 2 Yrs	038267 - Grandparent, Female, 51 Year(s)	DOA / Fatality	Unsubstantiated
038261 - Deceased Child, Female, 2 Yrs	038265 - Aunt/Uncle, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated
038261 - Deceased Child, Female, 2 Yrs	038264 - Aunt/Uncle, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
038261 - Deceased Child, Female, 2 Yrs	038264 - Aunt/Uncle, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated

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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The progress notes did not document ACS attempt to obtain medical request authorization from the parents, the PA's response towards ACS request and efforts to interview the 6-year-old cousin and PGM who were in the home at the time of the incident.

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 made diligent efforts; however, ACS was unsuccessful in locating the children, parents and subjects within the specified timeframe to adequately assess the safety of the other children in the home

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?	☐	☒	☐	☐

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 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:
As of 10/31/17, the PA's family was in receipt of PPRS.

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? No
Explain:
ACS offered services and the family refused.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS offered services and the family refused.

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? N/A
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)
03/16/2017	Other Child - Cousin, Female, 6 Years	Aunt/Uncle, Female, 25 Years	Excessive Corporal Punishment	Unfounded	Yes
	Other Child - Cousin, Female, 6 Years	Aunt/Uncle, Female, 25 Years	Swelling / Dislocations / Sprains	Unfounded	

Report Summary:
The 3/16/17 SCR report alleged the PA slapped the 6-year-old cousin in the face causing a red bump under her right eye

and general redness around that same eye. The PA did this as a punishment for the 6-year-old cousin slapping the 3-year-old cousin.

Determination: Unfounded | **Date of Determination:** 05/15/2017

Basis for Determination:
During the investigation the 6-year-old cousin was observed with a reddish, bumpy mark under her right eye. When asked about the mark the cousin stated the PA had slapped her. The PA denied she slapped the cousin and stated the cousin suffered from allergies. At ACS request, the PA took the cousin to the Dr. for an examination. The Dr. confirmed the cousin suffered from allergies dating back to 2016 and deemed the mark under her eye as a rash. The cousin was observed to be free from suspicious marks and bruises throughout the investigation.

OCFS Review Results:
The ACS Specialist gathered sufficient information to make determination for all allegations including those on the intake report in the course of the investigation. The determination made by ACS to unsubstantiated the report was appropriate. The safety decision recorded on the safety assessment at the time of the Investigation Determination was appropriate and commensurate with case circumstances.

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 the case circumstances because ACS inappropriately assigned the deceased child's BF as the Secondary Caretaker of the 6-year-old cousin.

Legal Reference:
18 NYCRR 432.2(d)

Action:
ACS must submit a PIP 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:
The Initial FASP was due on 6/16/17; however, the FASP was approved on 8/30/17.

Legal Reference:
18 NYCRR 428.3(f)(5)

Action:
ACS must submit a PIP 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 Case Recording/Progress Notes

Summary:
The review revealed progress for events that occurred on 3/16/17 were not entered contemporaneously. The entry date was listed as 5/12/17.

Legal Reference:
18 NYCRR 428.5

Action:

ACS must submit a PIP 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

The parents had no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

The parents had no known CPS history outside of NYS.

Preventive Services History

The parents had no Preventive History.

The PA had one prior investigation with ACS and an open FSS case for services. On 5/12/17, prior to the incident, a Child Safety Conference (CSC) was held to address the concerns for the PA and her children. ACS recommended preventive services of mental health and speech evaluation for the 6-year-old cousin as well as parenting skills training for the PA and PU. The PPRS agency had not been identified 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