Child Fatality Report

Report Identification Number: NY-17-080

Prepared by: New York City Regional Office

Issue Date: Jan 30, 2018

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: 1 day(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 08/05/2017
Initial Date OCFS Notified: 08/10/2017

Presenting Information

The 8/17/17 SCR report alleged that the SM had a 13-year history of heroin abuse, had been on methadone for the last 8 years and abused alcohol for the last 3 to 4 years. On 8/4/17, the SM took methadone and consumed alcohol while pregnant. SM became ill and was taken to the hospital where she removed all of the monitoring equipment herself and went into a corner and proceeded to push in attempts to induce labor. The SM was directed to immediately stop and was informed that her actions placed both her life and the infant (SC) at risk. The SC drew her first breath and lived until 8/5/17 before she expired due to premature birth and other medical conditions. The SM tested positive for alcohol at the time of delivery. The SM had a similar incident in 2015 where she delivered an infant as a result of methadone and alcohol ingestion. BF was aware of the SM's methadone and alcohol misuse and had continued to leave the SM alone with the three SS, ages 16, 13, 4 and cousin age 17.

Executive Summary

The newborn female child (SC) was one day old when she was pronounced dead. The SC died on 8/5/17 at 4:30 A.M. Following birth, the SC remained in the hospital and was not released to the SM. The ME did not perform an autopsy. ACS obtained copies of the Death Certificate which listed the SC's death as natural causes.

At the time of the SC's death, ACS had an open investigation to address concerns of the SM's history of alcohol/drug misuse, and to assess the family's needs and provide support services. During the open investigation, ACS found that the SM had delivered the SC prematurely at five months' gestation. At birth the SC was diagnosed with pre-existing medical conditions, the SC received medical care in the hospital until she was pronounced dead by the attending physician.

The SCR registered a report regarding the SC's death on 8/17/17. The allegations of the 8/17/17 SCR report were DOA/Fatality of the SC and other deceased child by the SM and SF, EdN and LMC of the SS age 16 and cousin (age 17) by the SM and SF, IG of the SC, other deceased child and SS by the SM and SF and PD/AM of the SC, other deceased child and four surviving children by the SM.

ACS investigated the 8/17/17 report and found there were three SS and a cousin (age 17) who lived in the home. ACS observed the four children and noted that these children did not have visible marks or bruises. ACS interviewed the SM and obtained her account of the incident. The SM denied using alcohol during her pregnancy. The SM explained that she was diagnosed with a medical condition and on 8/4/17 she became ill. The SM said she called 911 and EMS transported her to the local hospital. The SM reported that on 8/4/17, prior to the time she became ill, she drank one can of beer.

The SM confirmed that she had another child who died in 2015 as referenced in the 8/17/17 SCR report. ACS did not explore the circumstances of the other child's death. NYCRO issued Report Number NY-17-081 regarding to the child who died in 2015.

ACS findings showed that the SF resided in the home and provided financial support to the family. The SF denied he had observed the SM under the influence of drugs or alcohol while caring for the SS. He said the SS did not disclose substance abuse by the SM and he explained that he did not have concerns about the care the SM provided the SS. ACS documented that the SM drank alcohol during pregnancy prior to the death of the SC.

During an interview with the 13-year-old female SS, ACS learned that the SS was awakened by the SM who reported that

she was ill. The 13-year-old SS accompanied the SM to the local hospital. The 13-year-old SS provided information about the incident that led to the death of the SS. ACS staff engaged the cousin who stated that the SM drank alcohol but did not use drugs.

ACS interviewed hospital staff and learned that the SM tested positive for opiates; however, the SM had been given medication to treat her illness. The SM also tested positive for ethanol indicating there was none to mild alcohol use.

ACS staff obtained Family Court Legal Services (FCLS) consultation and attempted to file an Article Ten Neglect petition on behalf of the SS (to obtain COS for the family). FCLS directed the staff to delay Family Court intervention pending the results of ACS investigation. During the Initial Child Safety Conference (ICSC), ACS determined that the SM should continue with alcohol treatment and individual counseling. ACS referred the family to bereavement counseling and PPRS.

On 11/29/17, ACS unsubstantiated all the allegations of the 8/17/17 report on the basis of lack of credible evidence to support the allegations. As of 1/30/18, the case remained open for PPRS.

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?** Yes

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:
As of 1/30/18, the case remained open for PPRS.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	ACS did not make diligent efforts to obtain information from schools, Dr., PGM and MA.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or has taken 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 Risk Assessment Profile (RAP)
Summary:	ACS did not include information to reflect that a child in the family unit had been in the care of a substitute caregiver, and did not assess the impact of the SM's drug use on the care she provided the SS within the recent 2-year period.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or has taken 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 did not enter the progress notes in a timely manner.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or has 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 30-day fatality report was not completed within 30 days of receipt of the fatality report.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP 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.
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:	The 24-hour fatality report was not completed within 24 hours of receipt of the fatality report.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must submit a PIP 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/05/2017 **Time of Death:** 04:30 AM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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	Deceased Child	Alleged Victim		1 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	50 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Other Child - Cousin	Alleged Victim	Male	17 Year(s)
Deceased Child's Household	Other Deceased Child - Sibling, 3 days old	Alleged Victim	Female	0 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	13 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)

LDSS Response

Prior to the 8/17/17 investigation ACS convened an ICSC on 8/10/17. ACS determined that an Article Ten Neglect petition would be filed in Queens County Family Court (QCFC). ACS attempted to file the Article Ten Neglect petition in QCFC; however, the case was marked as delayed pending further investigative information. ACS contacted the SM's service provider and learned that the SM had been attending her services regularly and the SM had negative test results for all substances since January 2017.

On 8/17/17, ACS staff visited the home and observed the SM and SF were sober and lucid. ACS learned that the SM attended a methadone program. ACS did not observe indicators of alcohol abuse or drug paraphernalia in the home. ACS observed the three SS and a 17-year-old male cousin who was in the SM's care through a family arrangement. The ACS Specialist observed the SS and 17-year-old cousin were free of visible marks/bruises and dressed appropriately. The four children reported that they had not observed the SM under the influence of drugs/alcohol.

On 8/18/17, ACS visited the local hospital and interviewed medical personnel. ACS received an account of the events that occurred on 8/4/17. ACS learned that the SC died on 8/5/17 in the local hospital.

On 8/24/17, ACS obtained a medical consult to discuss the SM's medical condition. The consultant recommended that the ACS Specialist speak to the medical providers for further information regarding the SM's medical condition.

ACS staff made diligent efforts to obtain information from EMS liaison. ACS staff had attempted to obtain an account of the SM's behavior (to determine if the SM was intoxicated or exhibited irrational behaviors); however, ACS was unsuccessful in obtaining the information.

On 9/7/17, ACS sought a Mental Health and Substance Abuse consult. The consultants recommended that the SM enroll in treatment program, contact the SM's service provider (to discuss treatment plan), refer the SM and SF for parenting classes, bereavement counseling and PPRS.

ACS and Catholic Charities agency had a joint home visit on 9/22/17. The Catholic Charities agency discussed PPRS with the family. The family accepted services and signed for PPRS on 9/27/17.

ACS obtained a copy of the SC's death certificate on 10/13/17.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

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?Yes
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
043529 - Deceased Child, , 1 Days	043531 - Father, Male, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
043529 - Deceased Child, , 1 Days	043530 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
043529 - Deceased Child, , 1 Days	043530 - Mother, Female, 34 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated

043529 - Deceased Child, , 1 Days	043530 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
043529 - Deceased Child, , 1 Days	043531 - Father, Male, 50 Year(s)	DOA / Fatality	Unsubstantiated
043542 - Other Child - Cousin, Male, 17 Year(s)	043530 - Mother, Female, 34 Year(s)	Educational Neglect	Unsubstantiated
043542 - Other Child - Cousin, Male, 17 Year(s)	043531 - Father, Male, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
043542 - Other Child - Cousin, Male, 17 Year(s)	043530 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
043542 - Other Child - Cousin, Male, 17 Year(s)	043530 - Mother, Female, 34 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
043542 - Other Child - Cousin, Male, 17 Year(s)	043530 - Mother, Female, 34 Year(s)	Lack of Medical Care	Unsubstantiated
043542 - Other Child - Cousin, Male, 17 Year(s)	043531 - Father, Male, 50 Year(s)	Lack of Medical Care	Unsubstantiated
043542 - Other Child - Cousin, Male, 17 Year(s)	043531 - Father, Male, 50 Year(s)	Educational Neglect	Unsubstantiated
043543 - Sibling, Male, 16 Year(s)	043530 - Mother, Female, 34 Year(s)	Lack of Medical Care	Unsubstantiated
043543 - Sibling, Male, 16 Year(s)	043531 - Father, Male, 50 Year(s)	Lack of Medical Care	Unsubstantiated
043543 - Sibling, Male, 16 Year(s)	043531 - Father, Male, 50 Year(s)	Educational Neglect	Unsubstantiated
043543 - Sibling, Male, 16 Year(s)	043530 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
043543 - Sibling, Male, 16 Year(s)	043531 - Father, Male, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
043543 - Sibling, Male, 16 Year(s)	043530 - Mother, Female, 34 Year(s)	Educational Neglect	Unsubstantiated
043543 - Sibling, Male, 16 Year(s)	043530 - Mother, Female, 34 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
043544 - Sibling, Male, 4 Year(s)	043530 - Mother, Female, 34 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
043544 - Sibling, Male, 4 Year(s)	043530 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
043544 - Sibling, Male, 4 Year(s)	043531 - Father, Male, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
043545 - Sibling, Female, 13 Year(s)	043531 - Father, Male, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
043545 - Sibling, Female, 13 Year(s)	043530 - Mother, Female, 34 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
043545 - Sibling, Female, 13 Year(s)	043530 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
043621 - Other Deceased Child - Sibling, 3 days old, Female, 0 Year(s)	043530 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated

043621 - Other Deceased Child - Sibling, 3 days old, Female, 0 Year(s)	043530 - Mother, Female, 34 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
043621 - Other Deceased Child - Sibling, 3 days old, Female, 0 Year(s)	043531 - Father, Male, 50 Year(s)	DOA / Fatality	Unsubstantiated
043621 - Other Deceased Child - Sibling, 3 days old, Female, 0 Year(s)	043531 - Father, Male, 50 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?	☐	☒	☐	☐
Public or Private Child Care	☐	☒	☐	☐
School	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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:

During the 8/17/17 investigation, ACS did not enter progress notes in a timely manner and did not obtain pertinent information from the school and physician. ACS met the MA; however, the agency failed to obtain relevant information from the MA.

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 did not complete the 24-Hour safety assessment within 24 hours of receipt of the fatality in the 8/17/17 report.				

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	☒	☐	☐	☐
Explain: The assessment did not reflect a child in the RAP family unit was in the care of a substitute caregiver prior to the 8/17/17 report, and the negative impact of drug/alcohol use on the care the SM provided the children within the recent 2-year period.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐

Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: There was no removal as a result of the fatality.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☒	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☒	☐	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☒	☐	☐	☐	☐	☐	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: The family received PPRS through the Catholic Charities agency. The service plan included: intensive case management, CASAC case management, and mental health services.							

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 SS and the cousin (age 17) were referred to PPRS to address their immediate needs and support their well being in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM and SF were referred to counseling and PPRS.

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? Yes
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? Yes

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

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)
08/04/2017	Sibling, Male, 16 Years	Father, Male, 50 Years	Educational Neglect	Unfounded	Yes
	Sibling, Male, 16 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 4 Years	Father, Male, 50 Years	Inadequate Guardianship	Unfounded	
	Deceased Child on Report, Female, 0 Years	Father, Male, 50 Years	Inadequate Guardianship	Unfounded	
	Other Child - Cousin, Male, 17 Years	Mother, Female, 34 Years	Lack of Medical Care	Unfounded	

Sibling, Male, 16 Years	Father, Male, 50 Years	Lack of Medical Care	Unfounded
Other Child - Cousin, Male, 17 Years	Father, Male, 50 Years	Lack of Medical Care	Unfounded
Sibling, Male, 16 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unfounded
Sibling, Male, 4 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unfounded
Other Child - Cousin, Male, 17 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unfounded
Deceased Child on Report, Female, 0 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unfounded
Other Deceased Child - Sibling - three days old, Female, 0 Years	Father, Male, 50 Years	Inadequate Guardianship	Unfounded
Other Deceased Child - Sibling - three days old, Female, 0 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unfounded
Other Child - Cousin, Male, 17 Years	Mother, Female, 34 Years	Educational Neglect	Unfounded
Other Child - Cousin, Male, 17 Years	Father, Male, 50 Years	Educational Neglect	Unfounded
Sibling, Male, 4 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 13 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unfounded
Deceased Child on Report, Female, 0 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 13 Years	Father, Male, 50 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 13 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unfounded
Sibling, Male, 16 Years	Mother, Female, 34 Years	Educational Neglect	Unfounded
Other Child - Cousin, Male, 17 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 16 Years	Father, Male, 50 Years	Inadequate Guardianship	Unfounded
Other Child - Cousin, Male, 17 Years	Father, Male, 50 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 16 Years	Mother, Female, 34 Years	Lack of Medical Care	Unfounded

Report Summary:
The 8/4/17 SCR report alleged that on 8/4/17 sometime before 7:00 A.M., the SM went to the hospital because she was ill due to her pregnancy at five months gestation. The SM smelled of alcohol and was emotionally unstable and out of control. The SM stood against a corner of an exam room and attempted to force the baby out of her uterus prematurely despite urgent medical directives informing her that by pushing she was placing her infant's life and her own life at

imminent risk. After the infant was born, medical staff observed the infant (SC) was not breathing and was able to be resuscitated. The SC was in critical condition and admitted for ongoing medical care.

Determination: Unfounded | **Date of Determination:** 10/03/2017

Basis for Determination:
ACS unsubstantiated all the allegation of the 8/4/17 report. ACS documented that there was no credible evidence to support the allegations. ACS explained that during the investigation, none of the SS reported observing the SM drink alcohol on 8/4/17 or any time since the 11/17/16 investigation. The SC's death was not proven to be a direct result of the SM's alcohol intake. There was no indication that the SM behaved in a manner to place the SS at risk for harm. At the time of the SC's birth the report suggested SM was highly intoxicated; however, lab results contradicted the claim. There was no indication that the SF failed to protect the SS and was aware of maltreatment.

OCFS Review Results:
OCFS NYCRO's review revealed that ACS entered timely progress notes. ACS made thorough assessments regarding the family's needs. ACS conducted home assessments of the family's residences. ACS did not make relevant collateral contact to obtain information from the family Dr., school or day care. ACS did not state whether the agency interviewed the MA who was identified as a resource. ACS learned that the SM was caring for her 17-year-old nephew; however, the ACS Specialist did not probe further regarding the family arrangement. ACS did not document the whereabouts of the 17-year-old child's parents.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS did not obtain relevant information from the school, day care provider, PGM, MA, and Dr.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or has taken 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 Risk Assessment Profile (RAP)
Summary:
ACS did not include information to reflect that a child in the RAP family unit was in the care or custody of a substitute caretaker at some point prior to the 8/4/17 report.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or has taken 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)
11/17/2016	Sibling, Male, 15 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	Yes

Sibling, Male, 3 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 3 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Other Child - Cousin, Male, 17 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Other Child - Cousin, Male, 17 Years	Father, Male, 49 Years	Inadequate Guardianship	Indicated
Sibling, Female, 13 Years	Father, Male, 49 Years	Inadequate Guardianship	Indicated
Sibling, Male, 15 Years	Mother, Female, 33 Years	Lacerations / Bruises / Welts	Indicated
Other Child - Cousin, Male, 17 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 15 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 13 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 15 Years	Father, Male, 49 Years	Inadequate Guardianship	Indicated
Sibling, Male, 3 Years	Father, Male, 49 Years	Inadequate Guardianship	Indicated
Sibling, Female, 13 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated

Report Summary:
On 11/13/16 the SM got drunk and threatened to kill the male SS, who was then 15-years-old. On 11/14/16, the SS left school and did not return home because he feared the SM. The SS had not been home for four days. The SM had a problem with alcohol and drank alcohol to impairment while caring for the SS ages: 13, 15, and cousin age 17. On 11/14/16 the 17-year-old male cousin left the home for unknown reasons. The SF was aware of the SM's drinking but had not been able to address the SM's drinking. The SM was physically and verbally abusive to the 15-year-old male SS. The SM left redness on the 15-year-old male SS as a result. The 15-year-old male SS was afraid to go home.

Determination: Indicated | **Date of Determination:** 01/16/2017

Basis for Determination:
ACS substantiated the allegations of IG of the four children by the SM and SF, PD/AM of the four children by the SM and L/B/W of the SS, who was then 15 years old, by the SM. ACS found credible evidence to support the allegations. The SF was aware that the SM had an alcohol problem. The SM was admitted to the hospital for alcohol detoxification, yet the SF took no actions to protect the SS from the SM’s alcohol misuse. The SM's alcohol misuse had impaired her ability to care for the SS and ensure their needs were met. The SM was aware that the SS age 15 and cousin (age 17) needed medication and counseling yet the SM failed to ensure the two children received the required treatment.

OCFS Review Results:
OCFS NYCRO's review revealed ACS entered timely progress notes. ACS made thorough assessments regarding the family's needs; however, ACS did not follow-up with the service plan for the SS. ACS did not contact the family physician to discuss the SS medical needs. ACS identified the PGM as a supportive resource of the SS; however, ACS did not interview the PGM. ACS did not contact the SS's (age 3) daycare. ACS learned that the SM was caring for her 17-year-old nephew; however, the ACS Specialist did not probe further regarding the family arrangement. ACS did not obtain information about the whereabouts of the 17-year-old child's parents.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS did not obtain relevant information from pertinent collateral contacts, including the day care provider, PGM and Dr.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or has taken 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

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

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Required Action(s)

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

Issue:	Adequacy of Progress Notes
Summary:	The progress notes were not entered timely and often had entry dates that were three months after the event occurred.
Legal Reference:	18 NYCRR 428.5
Action:	The Catholic Charities agency must submit a PIP within 45 days that identifies the action the agency will take or has taken to address the citations identified in the fatality report. Catholic Charities 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 Risk Assessment Profile (RAP)
Summary:	The 11/7/17 RAP, did not include accurate information to reflect that a child in the RAP family unit was in the care or custody of a substitute caregiver, and the negative impact of the SM's alcohol use within the more recent two-year period.
Legal Reference:	18 NYCRR 432.2(d)
Action:	The Catholic Charities agency must submit a PIP within 45 days that identifies the action the agency will take or has taken to address the citations identified in the fatality report. Catholic Charities 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 Risk Assessment Profile (RAP)

Summary:	The 9/6/17 RAP assessment question 2 was marked no instead of yes.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must submit a PIP 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.
Issue:	Coordination of Services
Summary:	The Catholic Charities agency provided the SM with CASAC management services; however, the agency did not assess the three SSs and the 17-year-old cousin needs in a timely manner.
Legal Reference:	18 NYCRR 432.2(b)(4)(i) and 432.2 (b)(4)(viii)
Action:	Catholic Charities must submit a PIP within 45 days that identifies the action the agency will take or has taken to address the citations identified in the fatality report. Catholic Charities 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.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

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

Additional Local District Comments

There are no additional Local district comments.

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