# Child Fatality Report

## Report Identification Number: NY-18-010

## Prepared by: New York City Regional Office

## Issue Date: Jul 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:** 5 month(s)
**Jurisdiction:** New York
**Gender:** Female
**Date of Death:** 02/03/2018
**Initial Date OCFS Notified:** 02/05/2018

### Presenting Information

The 2/5/18 SCR report alleged that on 2/3/18, the SM and female children, ages 5 months and 1 year, were not at the shelter. The report also alleged the SM had taken the children to visit the MGM in New Jersey. On 2/3/18, during the night, the SF returned to the shelter and mentioned to staff that the SC, age 5 months, passed away. The SF stated that the SC was diagnosed with a heart murmur and stopped breathing. On 2/5/18, the SM spoke with staff and had limited information about the SC's cause of death; therefore, she did not provide an explanation. The SM did not know the cause of death, and mentioned that the hospital staff would provide her with further information. A specific determination about the cause of death had not been made at the time.

### Executive Summary

This 5-month-old female SC died on 2/3/18. NYCRO received the ME report on 7/11/18. The ME listed the cause of death as congestive heart failure due to atrial and ventricular septal defects and the manner of death as natural.

The allegations of the 2/5/18 report were DOA/Fatality and IG of the SC by the SM and SF.

At the time of the SC’s death, the family had an open preventive services case and had been receiving services beginning 10/2/17. The family was in receipt of COS for addressing DV, and health and housing needs.

During the 2/5/18 investigation, ACS gathered pertinent information from the State of New Jersey Department of Children and Families (NJDCF) after the NJDCF registered a report regarding the family. ACS also interviewed LE and medical professionals. Per the ACS case record, the SC had developmental and medical issues since birth. ACS followed up with the medical professionals and learned that the SM and SF had consistently taken the SC to the Dr. ACS attempted to discuss the circumstances of the SC’s death with the SM and SF on multiple occasions; however, ACS was unsuccessful because the SM and SF reported they were grieving. ACS interviewed the MGM to obtain information about the SC’s death and learned that the family was visiting the MGM when the SC stopped breathing. The SC was taken to the local hospital and was pronounced deceased.

ACS contacted the CAC and other medical professionals to verify that the SC was born with developmental and medical conditions. The Dr. reported that the SC received medical care at the local hospital to address her medical conditions. ACS did not follow-up with the local hospital to obtain details about the SC’s medical diagnoses. The ME reported that the SC had pre-existing medical conditions and was free of internal injuries and trauma.

On 2/6/18, the ACS Specialist contacted the NJDCF. The NJDCF child protection staff observed the SS was free of suspicious marks and bruises. The child protection staff determined the home environment was adequate and presented with no hazardous conditions. On 2/5/18, ACS utilized the HOP (Heightened Oversight Process) and a Child Safety Conference (CSC) to provide ongoing assessment of the family.

On 4/24/18, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the SM and SF on the basis that the ME's preliminary findings showed there were no outward signs of abuse/maltreatment of the SC. The SC passed away due to a medical condition.

As of 7/30/18, the preventive services case remained open.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** No
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

**Determination:**

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

**Explain:**
ACS did not gather sufficient information from relevant collateral contacts to make the decision recorded on the initial safety assessment.

**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:**
ACS closed the investigation on 4/24/18 and the service case remained open with extensive PPRS and COS.

### 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 complete the 24-hour Fatality Report document in a timely manner. The SCR report was dated 2/5/18 and the 24-hour Fatality Report document was completed on 2/8/18. |
| **Legal Reference:** | CPS Program Manual, Chapter 6, K-1 |
| **Action:** | ACS must submit a PIP within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed. |

| | |
|---|---|
| **Issue:** | The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment. |
| **Summary:** | ACS did not complete the 30-day Fatality Report document in a timely manner. The SCR report was dated 2/5/18 and the 30-day Fatality Report document was completed on 4/13/18. |
| **Legal Reference:** | CPS Program Manual, VIII, B.2, p.4 |
| **Action:** | ACS must submit a PIP within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed. |

| | |
|---|---|
| **Issue:** | Contact/Information From Reporting/Collateral Source |
| **Summary:** | The ACS Specialist did not follow-up to obtain information from the SS's physician. |
| **Legal Reference:** | 18 NYCRR 432.2(b)(3)(ii)(b) |
| **Action:** | ACS must submit a PIP within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed. |

| | |
|---|---|
| **Issue:** | Timely/Adequate 30-Day Safety Assessment |
| **Summary:** | ACS did not complete a 30-day safety assessment document. |
| **Legal Reference:** | CPS Program Manual, Chapter 6, K-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 Seven Day Assessment |
| **Summary:** | ACS did not complete the seven day safety assessment document. |
| **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. |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 02/03/2018 **Time of Death:** Unknown

**Time of fatal incident, if different than time of death:** 06:36 PM

**Was 911 or local emergency number called?** Yes
**Time of Call:** 06:36 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?** Unable to determine

**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 | Female | 5 Month(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 25 Year(s) |
| Other Household 1 | Mother | Alleged Perpetrator | Female | 25 Year(s) |
| Other Household 1 | Sibling | No Role | Female | 1 Year(s) |

**LDSS Response**

On 2/5/18, the ACS Emergency Children's Services (ECS) staff interviewed the shelter staff who confirmed that the SM and SF resided in a NYC shelter with the SC and SS. The staff said the SC passed away at a local hospital in New Jersey. The ECS staff obtained information for an aunt to verify the recent fatality. The SM and SF reported that the SC passed away on 2/3/18.

On 2/5/18, ACS contacted a community resource who said the family resided at the shelter for two months. The community resource reported that the children appeared clean and seemed to have received adequate care. ACS learned that the family adhered to shelter rules and regulations and there were no reported concerns. The SM had provided the shelter with the SS and SC's medical information and did not appear to be overwhelmed with caring for the SC and SS.

On 2/5/18, ACS contacted the NJDCF about the circumstance of the SC's death. The NJDCF registered a report regarding the SC's death. On 2/6/18, ACS learned that the NJDCF staff visited the MGM's home in New Jersey and assessed the SM and SS. The SS did not have visible marks/bruises. The SS's account was not obtained, because she appeared to be too young to be interviewed. The SM and SF did not respond to questions as they were reportedly grieving the SC's death.

ACS contacted the Bronx CAC Director to obtain medical information about the SC. The CAC director declined to give ACS the medical records; therefore, ACS documented that the Family Court Legal Services (FCLS) attorney intervention would be sought. ACS staff did not follow-up with the FCLS attorney regarding the SC's medical records.

Between 2/20/18 and 3/1/18, ACS attempted face-to-face and telephone contact with the SM, SF and SS but was unsuccessful. On 3/3/18, ACS met with the SM and SS in the home and discussed the continuing PPRS services and an

Initial CSC.

On 3/13/18, ACS convened a CSC and discussed the family's service needs and continued COS. The SM and SF did not attend the CSC although ACS had provided multiple notifications of the meeting.

On 3/23/18, ACS conducted a joint home visit with the PPRS agency and the family declined counseling services. The case planner discussed DV services and bereavement counseling with the family.

On 4/10/18, ACS received the ME's final report which listed the cause of death as a medical illness and the manner of death as natural.

## 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:** 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 |
|---|---|---|---|
| 046936 - Deceased Child, Female, 5 Mons | 046938 - Father, Male, 25 Year(s) | DOA / Fatality | Unsubstantiated |
| 046936 - Deceased Child, Female, 5 Mons | 046938 - Father, Male, 25 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 046936 - Deceased Child, Female, 5 Mons | 046937 - Mother, Female, 25 Year(s) | DOA / Fatality | Unsubstantiated |
| 046936 - Deceased Child, Female, 5 Mons | 046937 - Mother, 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?** | ☐ | ☒ | ☐ | ☐ |
| First Responders | ☐ | ☒ | ☐ | ☐ |
| Law Enforcement | ☐ | ☒ | ☐ | ☐ |
| **Was a death-scene investigation performed?** | ☒ | ☐ | ☐ | ☐ |
| **Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?** | ☒ | ☐ | ☐ | ☐ |
| **Coordination of investigation with law enforcement?** | ☒ | ☐ | ☐ | ☐ |
| **Did the investigation adhere to established protocols for a joint investigation?** | ☒ | ☐ | ☐ | ☐ |
| **Was there timely entry of progress notes and other required documentation?** | ☒ | ☐ | ☐ | ☐ |

**Additional information:**
ACS did obtain information from the first responders.

## 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 7-day and 30-day safety assessment documents that were required for the case.

## 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 SM and SF refused bereavement and counseling services. | | | | |

## 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 of the SS. | | | | |

## Legal Activity Related to the Fatality

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

**Have any Orders of Protection been issued?** No

## Services Provided to the Family in Response to the Fatality

| Services | Provided After Death | Offered, but Refused | Offered, Unknown if Used | 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 SM and SF received services through COS. The ACS Specialist offered the SM and SF mental health and burial assistance. The subject parents declined 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 received Early Intervention and ongoing assessment through case planning agency and COS by ACS.

**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 enrolled in PPRS services and continued COS. The SM and SF were offered bereavement counseling.

## 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
☐ Had heavy alcohol use
☐ Misused over-the-counter or prescription drugs
☐ Smoked tobacco

☐ Experienced domestic violence
☐ Used illicit drugs
☒ Was not noted in the case record to have any of the issues listed

**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) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 09/25/2017 | Sibling, Female, 11 Months | Father, Male, 23 Years | Inadequate Guardianship | Substantiated | Yes |
| | Deceased Child, Female, 1 Months | Father, Male, 23 Years | Inadequate Guardianship | Substantiated | |
| | Sibling, Female, 11 Months | Mother, Female, 24 Years | Inadequate Guardianship | Substantiated | |
| | Deceased Child, Female, 1 Months | Mother, Female, 24 Years | Inadequate Guardianship | Substantiated | |

**Report Summary:**
The 9/25/17 SCR report alleged that on 9/25/17, the SM and the SF had an argument which escalated to physical violence. The SM hit the SF in the face with an open hand in front of the SS and SC.

**Report Determination:** Indicated
**Date of Determination:** 11/24/2017

**Basis for Determination:**
ACS substantiated the allegation of IG of the SC and SS by the SM and SF on the basis that on 9/25/17, the BM slapped the BF in the presence of the SC and SS. ACS explained that on 10/14/17, the SM and SF engaged in another DV incident involving physical violence. ACS noted there was credible evidence to substantiate the allegation of the 9/25/17 report.

**OCFS Review Results:**
OCFS NYCRO's review revealed ACS entered progress notes contemporaneously. ACS made a thorough assessment of the family's service needs and obtained relevant information from the Investigative Consultant. ACS did not document information about safe sleep practice or discussion with the parents prior to the SC's death. ACS documented that requests for medical records were sent to the physicians; however, there was no follow-up casework activity regarding the medical records. The ACS supervisor and manager did not follow-up to make certain the ACS Specialist obtained the medical records.

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

**Issue:**
Failure to Provide Notice of Indication
**Summary:**
ACS did not provide the Notice of Indication to the SM and SF who were the subjects of the 9/25/17 report.
**Legal Reference:**
18 NYCRR 432.2(f)(3)(xi)
**Action:**

ACS must submit a PIP within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.

**Issue:**
Contact/Information From Reporting/Collateral Source
**Summary:**
ACS did not follow-up to obtain medical information from the physician who was identified in the progress notes.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(b)
**Action:**
ACS must submit a PIP within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.

**Issue:**
Failure to provide safe sleep education/information
**Summary:**
The ACS Specialist did not document whether safe sleep discussion/education session was held with the SM and SF.
**Legal Reference:**
13-OCFS-ADM-02
**Action:**
ACS must submit a PIP within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.

**Issue:**
Predetermination/Assessment of Current Safety and Risk
**Summary:**
In the safety assessment document dated 11/20/17, ACS selected a Safety Decision that stated there was no safety factor that placed the children in immediate danger. The 11/20/17 document was inaccurate because ACS had determined safety intervention was necessary to protect the children.
**Legal Reference:**
18 NYCRR 432.1(aa)
**Action:**
ACS must submit a PIP within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.

[redacted]

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

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

## Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

# Services Open at the Time of the Fatality

**Was the deceased child(ren) involved in an open preventive services case at the time of the fatality?** Yes

**Date the preventive services case was opened:** 10/02/2017

**Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality?** Yes
**Date the Child Protective Services case was opened:** 10/02/2017

## Evaluative Review of Services that were Open at the Time of the Fatality

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?** | ☒ | ☐ | ☐ | ☐ |

## Family Assessment and Service Plan (FASP)

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Was the most recent FASP approved on time?** | ☐ | ☒ | ☐ | ☐ |
| **If not, how many days was it overdue?** The Reassessment FASP was due on 12/31/17 and was not completed in a timely manner. The FASP was completed on 4/17/18 and was four months overdue. | | | | |
| **Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?** | ☒ | ☐ | ☐ | ☐ |
| **Was the FASP consistent with the case circumstances?** | ☐ | ☒ | ☐ | ☐ |

## Closing

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Was the decision to close the Services case appropriate?** | ☐ | ☐ | ☒ | ☐ |

## Provider

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Were Services provided by a provider other than the Local Department of Social Services?** | ☒ | ☐ | ☐ | ☐ |
| **Additional information, if necessary:** The family received PPRS through the Lower East Side Family Union agency. | | | | |

## Required Action(s)

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

| | |
|---|---|
| **Issue:** | Adequacy of case recording in FASP |

| | |
|---|---|
| **Summary:** | ACS selected a Safety Decision in the FASP that stated there was no safety factor that placed the children in immediate danger although the family had a history of DV and safety intervention and safety plan was necessary. |
| **Legal Reference:** | 18 NYCRR 428.6(a) |
| **Action:** | ACS must submit a PIP within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed. |
| | |
| **Issue:** | Timeliness of completion of FASP |
| **Summary:** | The 12/31/17 Reassessment FASP was due on 12/31/17 and was not completed in a timely manner. The FASP was completed on 4/17/2018 and was four months overdue. |
| **Legal Reference:** | 18 NYCRR428.3(f) |
| **Action:** | ACS must submit a PIP within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed. |
| | |

## Preventive Services History

On 10/2/17, ACS opened a preventive services case for the family. ACS filed an Article Ten Neglect petition in the Family Court on behalf of the 1-year-old SS and the SC. The Family Court recommendation included an OP and referral to preventive services. ACS referred the family to the Puerto Rican Family Institute agency; however, the family was unable to engage in services because they were moving from shelter to shelter. According to the Case Planner, the family did not sign an agreement to receive PPRS with the Puerto Rican Family Institute agency and was difficult to engage. ACS referred the family to the Lower Eastside Family Union agency on 1/29/18. ACS provided COS services and made face-to-face contact with the family on 1/8/18, 12/4/17, and 11/13/17. There were no documented discussions around the SC's pre-existing medical condition between October 2017 and December 2017. The preventive service case was open when ACS received notification of the SC's death.

## Legal History Within Three Years Prior to the Fatality

**Was there any legal activity within three years prior to the fatality investigation?**

☒Family Court ☐Criminal Court ☒Order of Protection

| **Family Court Petition Type:** FCA Article 10 - CPS | | |
|---|---|---|
| **Date Filed:** | **Fact Finding Description:** | **Disposition Description:** |
| 10/18/2017 | There was not a fact finding | There was not a disposition |
| **Respondent:** | 046937 Mother Female 25 Year(s) | |
| **Comments:** | ACS filed an Article X Neglect petition in the Bronx County Family Court (BCFC) against the SM on behalf of the SC and SS on 10/18/17. The BCFC granted ACS COS. | |

**Have any Orders of Protection been issued?** Yes

| **From:** 01/23/2018 | **To:** 04/13/2018 |
|---|---|
| **Explain:** The BCFC judge issued an order of protection against the SM. The protected person was not specified in the report. | |

## Additional Local District Comments

There were 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