Child Fatality Report

Report Identification Number: NY-18-032

Prepared by: New York City Regional Office

Issue Date: Sep 25, 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: 2 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 03/29/2018
Initial Date OCFS Notified: 04/02/2018

Presenting Information

The 4/2/18 SCR report alleged that during the late evening of 3/26/18, the parents fed the SC at the family home. The SC was subsequently placed in a crib, face down, atop a pillow. Upon checking on the SC an hour later, the SF noticed the SC's skin appeared blue and the SC was found to be unresponsive. The emergency number 911 was contacted, and efforts to resuscitate the SC were made. The SC was later transported via ambulance to the hospital, where he was intubated and admitted during the early morning hours of 3/27/18. The medical professionals later determined the SC was brain dead after two rounds of testing. The SC remained hospitalized until he was pronounced dead. The SC had no known medical condition that would have brought about these events.

Executive Summary

The 2-month-old male child (SC) died on 3/29/18. The autopsy listed both the cause and manner of death as Undetermined.

At the time of the SC's death, the family had an open investigation that began on 3/27/18. The 3/27/18 report included the allegation of IG of the SC by the SM and SF. On 4/2/18, the SCR registered a report that included the allegations of DOA/Fatality and IG of the SC by the SM, SF and two grandparents.

ACS learned that on 3/26/18, at about 10:30 PM, the SM gave the SC a bath and prepared him for bed. After the bath, the SC fell asleep for almost 15 minutes. He awoke and the SM fed him. He fell asleep again for about 15-30 minutes. The SM said the SC was in his crib at this time. The SC awoke and she picked him up and comforted him. Once he fell asleep she placed him on his stomach with his face to the side. She said she and the SF had been placing a “standard size” pillow in the crib and they would place the SC on his stomach on the pillow. The SM explained that the SC had neck control and she added that she felt comfortable placing him in this position. There were no other items in the crib. The SM said she was aware of safe sleep practices. The SM said they were in the living room and the SC was asleep in the room. She could not recall the time the SF went to check him, but when the SF was in the room, she heard the SF scream and she went into the room. The SM observed the SC was unresponsive and the SF performed CPR. She took the SC from him, laid the SC on the bed, and administered CPR until EMS arrived. While she performed CPR, she observed milk come out of the SC’s mouth. EMS arrived and transported the SC to the hospital. The SM could not recall the amount of time that had transpired between the time she placed the SC to sleep and the time the SF found him unresponsive. The SM said she and the SF periodically observed the SC but was unable to provide specific intervals. The female half-sibling was in the home and she was asleep at the time the incident occurred.

On 3/27/18, the MA said she was asleep on the sofa. She awoke to the SM's screams and observed the SM and SF experience panic. The SF was on the phone with 911 and the SM performed CPR. When the SM performed CPR, the MA observed the SC vomited milk with small traces of blood and the SC was pale. The MA took the SC from the SM, put him on her shoulder and patted him on the back. Then the SM took the SC from her and went to the SF and took the phone from him. The SM went out of the room, knocked on the MGF's door and told him to call 911.

On 4/2/18, LE found there was no criminality in the case. LE had received a call from the ME on 3/29/18. The ME had informed LE that the SC was in the hospital and was brain dead. The SC was connected to life support on 3/29/18. LE had no concerns regarding the half-sibling.

On 4/19/18, the ME reported there were no concerns of child abuse/maltreatment. The ME met with the SM and SF and observed they were appropriate and showed concern about the SC's circumstances. Later, the ME found the SM and SF gave the SC tea in the formula the night of the incident. According to the ME, the SM and SF were forthcoming and expressed concern that they may had done something to cause the passing of the SC. The ME said the tea was not a contributing factor to the SC's death. The SM and SF informed the ME that the SC was placed on a pillow when he had been put to sleep.

The 30-Day Child Fatality Summary Report was not completed timely as it was not completed until 7/24/18. The 7-Day safety assessment for the 4/2/18 report was not completed until 4/18/18.

The CPS investigation had not yet been determined at the time of issuance of this fatality report.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

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:
NA

Required Actions Related to the Fatality

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

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 Child Fatality Summary Report was not completed timely as it was not completed until 7/24/18.
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:	The 7-Day safety assessment for the 4/2/18 report was not completed until 4/18/18.
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:	Face-to-Face Interview (Subject/Family)
Summary:	The documentation of the 4/2/18 investigation did not reflect that the SF was interviewed pertaining to the timeline of the incident. He was interviewed pertaining to the SC's meals that included the tea.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/29/2018 **Time of Death:** 01:20 PM

Date of fatal incident, if different than date of death: 03/27/2018
Time of fatal incident, if different than time of death: 01:50 AM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 01:56 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
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? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	46 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other Adult - maternal great grandfather	Alleged Perpetrator	Male	75 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)

LDSS Response

On 4/2/18, the ME said there were no signs of physical trauma and the SC seemed to have received adequate care. LE informed the ME that the SM fed the SC at about midnight. The SM gave the SC formula mixed with one teaspoon of tea. The SM put the SC in his crib face up and when she returned the SC was found face down with a pillow underneath his face. The medical staff resuscitated him, but he had severe brain injury. According to ACS, both explanations (SC placed face up and placed down) were provided for the ME's investigation by the family and ACS.

On 4/3/18, during interviews with ACS, the SM said the half-sibling stayed with the MGM and MGGM in Westchester County. Regarding the SC's diet, the SM said the SC was sometimes provided tea in his bottle at night. The SM said she made the tea with water in the bottle. The SF said he and the SM informed the physician that they put tea in the milk and the physician did not express concern.

On the same day, ACS visited the home of the MGGM and assessed the half-sibling. The half-sibling said she was ill on 4/2/18 and went to the physician on 4/3/18. This physician prescribed two medications and ACS observed the prescriptions were filled. The MGM said she did not reside in New York State (NYS). She said she usually took the half-sibling out of NYS for the summer. She informed ACS that she did not have concerns regarding the level of care the SM and SF provided the SC and half-sibling.

On 4/12/18, the half-sibling was seen at the CAC for a forensic interview. ACS documentation reflected the half-sibling was in the home at the time of the incident involving the SC. The half-sibling observed the SM and SF's actions that were in response to the incident.

On 4/18/18, ACS interviewed Safe Horizons staff and noted that an appointment had been scheduled to determine whether the family needed the services. Safe Horizon would assist with linking the family with bereavement services.

On 5/9/18, a case conference occurred that included a legal consultation. The Family Court Legal Service (FCLS) attorney said more information was necessary to determine whether there was a basis to file an Article Ten Neglect petition on behalf of the half-sibling.

On 5/16/18, ACS attempted to obtain medical information for both CHN. The documentation did not indicate whether ACS followed up to secure the medical records.

On 5/29/18, ACS visited the home and the SM informed ACS that the family needed to find a new place to reside. The SM said they had to relocate due to changes in the MGF's employment. ACS reminded the SM that Safe Horizon could provide her with resources. ACS told the SM that ACS was going to forward her information for the Parent Support Group and the individual counseling for the half-sibling.

On 6/25/18, the SM said she prepared the half-sibling for her trip to the MGM's home out of NYS. ACS told the parents that they would be informed about a date for a conference. The SF said if he was available he would attend. The SM said she would be available by phone.

ACS requested a visit be conducted to the MGM's home to assess the half-sibling by the Texas Department of Social Service (TDSS). The CH was seen by TDSS staff who reported there were no concerns.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or 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 investigations.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047301 - Deceased Child, Male, 2 Mons	047306 - Grandparent, Male, 46 Year(s)	DOA / Fatality	Pending
047301 - Deceased Child, Male, 2 Mons	047304 - Father, Male, 29 Year(s)	Inadequate Guardianship	Pending
047301 - Deceased Child, Male, 2 Mons	047307 - Other Adult - maternal great grandfather, Male, 75 Year(s)	DOA / Fatality	Pending
047301 - Deceased Child, Male, 2 Mons	047306 - Grandparent, Male, 46 Year(s)	Inadequate Guardianship	Pending
047301 - Deceased Child, Male, 2 Mons	047303 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Pending
047301 - Deceased Child, Male, 2 Mons	047307 - Other Adult - maternal great grandfather, Male, 75 Year(s)	Inadequate Guardianship	Pending
047301 - Deceased Child, Male, 2 Mons	047304 - Father, Male, 29 Year(s)	DOA / Fatality	Pending

047301 - Deceased Child, Male, 2 Mons	047303 - Mother, Female, 24 Year(s)	DOA / Fatality	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
School	☐	☐	☐	☒
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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The documentation did not reflect that the staff of the half-sibling's school was interviewed, and whether ACS interviewed the SF pertaining to 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?	☐	☐	☒	☐

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: NA				

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.

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	☐	☐	☐	☐	☐	☒	☐

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 documentation reflected ACS planned to forward to the SM information for the parent support group and the individual counseling for the half-sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
On 4/3/18, ACS addressed burial assistance with the SM. The SM informed ACS that the family had addressed the burial arrangements.

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)	Allegation Outcome	Compliance Issue(s)
03/27/2018	Deceased Child, Male, 2 Months	Father, Male, 29 Years	Inadequate Guardianship	Pending	Yes
	Deceased Child, Male, 2 Months	Mother, Female, 24 Years	Inadequate Guardianship	Pending	

Report Summary:
The 3/27/18 SCR report alleged that on 3/26/18, at approximately 10:30 PM, the SM and SF laid the SC face down on a pillow to sleep. At approximately 1:00 AM, the SF found the SC blue in color; he had stopped breathing and went into full cardiac arrest. The SF called 911 and attempted CPR. The SC was taken to the hospital, had to be intubated and was in critical condition.

Report Determination: Undetermined

OCFS Review Results:
On 3/27/18, the social worker (SW) said the parents reported that during the night of 3/26/18, they placed the SC face down on a pillow in his crib as he was the most comfortable in that position. The parents did their usual half hour checks on the SC. Everything was well until between 11:30 PM-1:00 AM, when the SF checked the SC and observed the SC was blue and unresponsive. The SF called 911 and attempted CPR. The SC's prognosis was grim. On 3/29/18, LE informed ACS that at 1:20 PM, the SC was pronounced dead by hospital staff; however, he remained connected to life support. On 4/2/18, the SCR registered a report regarding the SC's death.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
ACS did not enter the Investigation Progress Notes contemporaneously, including an event that occurred on 4/10/18, but was not entered until 5/21/18.

Legal Reference:
18 NYCRR 428.5(a) and (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:
Face-to-Face Interview (Subject/Family)
Summary:
The documentation of the 3/27/18 investigation did not reflect that the SF was interviewed pertaining to the timeline of the incident.
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.

[redacted]

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

The SM and SF were not known to the SCR or ACS as subjects more than three years prior to the fatality.

The MGF was known to the SCR and ACS as a subject in two reports dated: 3/5/09 and 3/24/10. The allegations of the 3/5/09 report were CD/A, EdN, IG, LS, SA and PD/AM. The report was IND on 4/14/09. The allegations of the 3/24/10 report was IG and PD/AM. The report was IND on 5/10/10.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

During the 3/5/09 investigation, ACS opened a services case was opened on 3/18/09. The case had been referred to ACS after the MGM and MGF went to Family Court and requested services to address the SM's drug use, difficult behavior and truancy. The MGF and SM were assessed for treatment and services; the MGM returned to reside out of NYS. The 4/23/10 FASP reflected that on 4/6/09, ACS referred the case to the Alianza Dominicana, Inc., agency. The family received substance abuse treatment services for the MGF, supportive therapy, case management, educational counseling, prenatal services, and other educational and support services for the SM. The SM and the female half-sibling were assessed to be safe.

During participation in PPRS, it was observed that the SM made certain the half-sibling received the minimum degree of care. The half-sibling was referred for an Early Intervention evaluation. The SM and her CH no longer resided with the MGF as they relocated to reside with the MGM's out of NYS. ACS closed the services case on 5/20/10.

The SM was involved in a COI as an FSS was opened on 8/23/13 and closed on 5/9/14.

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