Child Fatality Report

Report Identification Number: NY-18-052

Prepared by: New York City Regional Office

Issue Date: Nov 06, 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: 3 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 05/27/2018
Initial Date OCFS Notified: 05/27/2018

Presenting Information

The 5/27/18 SCR reports alleged the SC died while in the care of his parents. The SC was an otherwise healthy CH with no known pre-existing medical conditions. On 5/27/18, the SC was found unresponsive at 8:58 AM in the home while in the care of the parents and PA. The SC was pronounced dead at 9:50 AM.

Executive Summary

The 4-month-old male SC died on 5/27/18. According to the ME, the preliminary findings showed there were no marks or bruises observed on the SC. There were no signs of trauma and the autopsy was pending further studies. NYCRO had not yet received the autopsy report at the time the fatality report was issued.

The SCR registered two reports on 5/27/18 regarding the SC's death. The allegations of the two reports were DOA/Fatality and IG of the SC by the SM, SF and PA.

ACS interviewed the SM and SF on the circumstances surrounding the death of the SC. The SM said she usually fed the SC at 4:00 AM and between 7:00 AM and 8:00 AM. On 5/27/18, the SM last saw the SC alive at approximately 4:00 AM, when she fed the SC formula with a “pinch” of cereal and placed the SC in the bassinet to sleep. Around 8:50 AM, the SM realized the SC had not woken up. The SM touched the SC and he felt cold. The SM alerted the SF and PA. The SF called 911 and the PA performed CPR. EMS arrived at the scene and resumed CPR. Via ambulance, the SC and parents were escorted to the hospital ER. Resuscitative measures were continued by hospital staff; however, the SC was declared dead.

According to the SM, the SC slept alone in the bassinet all night. The SM denied co-sleeping with the SC. ACS and LE reviewed the statements obtained from the parents and PA and found there was a discrepancy concerning the SC's sleeping environment.

The family resided in the PA’s furnished 2-bedroom apartment. Regarding the sleeping arrangements, the SM slept in a bedroom with a full-size bed. The family had an infant rocker which the SM referred to as the bassinet, where the SC usually slept and a pack and play. ACS assessed the home contained adequate food and provisions for the family. ACS observed in-place window guards and an uninstalled smoke/carbon monoxide detector; which the SM affixed to the wall at the time of the visit. ACS observed the SS appeared healthy and did not have observable marks/bruises. There were no safety hazardous noted.

During the investigation ACS held an initial children safety conference (ICSC). ACS found there were no medical record to verify the SC was medically seen for a congestion illness as alleged by the parents. The CHN lack of updated medicals, unstable housing condition and the SM and SF's history of substance use and mental health issues; respectively, were noted concern. ACS recommended Family Court intervention and services. ACS sought Family Court intervention and the SS remained in the SM and SF's care with court ordered supervision (COS). The SM and SS relocated to a shelter. ACS opened a preventive services case and referred the family for PPRS. On 7/26/18, a child safety conference was held; the parents were enrolled in services and the SS had up to date medicals. On 8/17/18, the SM and SS obtained permanent housing. ACS provided the family furniture assistance. On 8/23/18, ACS conducted a joint home visit with the PPRS agency. On 9/17/18, the CW had no concerns as the SS appeared well and the SM provided a minimum degree of care.

On 7/28/18, ACS unsubstantiated the allegation of DOA/Fatality of the SC by the SM, SF, and PA and IG of the SC by

the PA. ACS explained the ME's final report was pending the results of additional tests.

ACS substantiated the allegation of IG of the SC by the parents as they admittedly slept in the same bed as the CHN and the SM co-slept with the SC the morning of the incident. The parents did not provide an appropriate sleeping environment for the SC. ACS added and substantiated the allegation LMC of the SC and SS by the parents on the basis they failed to provide preventive medical care of the CHN despite the family having medical coverage. The three elder SS had not received routine medical care in over a year nor had the SC and one-year-old SS been medically seen since their births.

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:
On 6/1/18, a services case was opened. As per the 6/6/18 court order, ACS supervised the family and referred the family to case management, DC, parenting, homemaking, EI, MH and counseling services with New York Foundling agency.

Required Actions Related to the Fatality

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

Issue:	Failure to Provide Notice of Indication
Summary:	ACS substantiated the allegations of IG and LMC and the 5/27/18 report was indicated; however, the NOI was not generated nor did the progress notes reflect the NOI was provided to the SM and SF prior to closing the investigation.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)

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: 05/27/2018 **Time of Death:** 09:50 AM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 08:58 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	55 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	5 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)

Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)

LDSS Response

On 5/27/18, LE informed ACS that 911 was called at 8:58 AM on 5/27/18. The SF performed CPR on the SC, as instructed by the 911 operator. EMS responded to the home around 9:05 AM. The SC was transported to the hospital and declared dead at 9:50 AM. LE found there was a discrepancy between the SM and PA's statements.

On 5/27/18, the attending physician stated the SM reported the SC was fed around 4:30 AM and was placed face up in the crib. The SM checked the SC around 9:00 AM and found the SC was unresponsive. The physician reported rigor mortis had set in on the SC upon the SC's arrival at the hospital.

On 5/27/18, all SS were seen by ACS at the CAC. The SS did not have suspicious marks/bruises. The eldest SS stated the SC slept in the middle of the bed, between him and the SM. The four-year-old SS stated he sometimes slept with the SM and SC on the bed. Due to his age, the two-year-old SS was unable to provide clear responses to most of the interviewer's questions.

On 5/27/18, the PA said the SM, SF, SC and SS lived with her for 15 months. At approximately 8:30 AM, the PA recalled she peered into the SM's bedroom and observed the SC and two-year-old SS were asleep on the bed. Sometime later, the SM alerted the PA and SF that the SC was not breathing. The PA took the SC into her arms; the SC's body was cold and his lips were purple. The SF called 911 and she performed CPR. EMS arrived and the SS were in the PA's care while the SM and SF were at the hospital with the SC. According to the PA's account, she slept in one bedroom and the SM slept in another room with the SC, who slept in the bassinet that was a rocker. The PA stated her teenage son primarily lived with his grandparents and was not present at the time of the incident.

On 5/28/18, the SF stated the family was outside of the home until about 10:00 PM on 5/26/18. The SM took the CHN upstairs and placed them to sleep. At approximately midnight, the SM fed the SC and gave the SC a pacifier. The SM alerted the SF and PA that the SC was unresponsive. The SF called 911 and received CPR coaching and CPR was provided by the PA until EMS arrived. The SF stated the SC usually slept in the rocker; however, on the day of the incident the SC slept in the rocker on the same surface with the SM.

On 5/29/18, the hospital staff reported the SM received safe sleep practices training prior to discharge. According to staff, the SM reported the SC and SS were medically seen at a neighborhood physician's office.

ACS contacted the PGM and MGM who both had no concerns regarding the care the parents provided the SC and SS or their ability to protect them.

On 5/30/18, ACS contacted the Dr.'s office and learned that the three eldest SS were not up to date on immunizations and they had no pre-existing medical conditions. The SC and one-year-old SS had no medical history with the Dr.'s office.

According to the school staff, there were no concerns regarding the SS academic performance, behavior or the care the SM and SF provided.

On 5/31/18, the SM and SS relocated to a shelter due to overcrowding; however, the SF decided to remain at the PA's home.

On 6/5/18, the parents attended the ICSC held at the LDSS office. ACS identified their strengths and noted concerns

related to the SS ages and lack of preventive medical care, unstable housing, the parents history of marijuana use and alcohol consumption, the SF admitted history of mental heath issues and the parents' history of not following through to complete offered services.

On 6/6/18, ACS filed an Article Ten Neglect petition in Bronx County Family Court (BCFC). BCFC ordered the SS to remain with the SM and SF under ACS supervision and mandated the family to comply with ACS service recommendations.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047872 - Deceased Child, Male, 3 Mons	047873 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
047872 - Deceased Child, Male, 3 Mons	047941 - Aunt/Uncle, Female, 55 Year(s)	DOA / Fatality	Unsubstantiated
047872 - Deceased Child, Male, 3 Mons	047873 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
047872 - Deceased Child, Male, 3 Mons	047874 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
047872 - Deceased Child, Male, 3 Mons	047873 - Mother, Female, 24 Year(s)	Lack of Medical Care	Substantiated
047872 - Deceased Child, Male, 3 Mons	047941 - Aunt/Uncle, Female, 55 Year(s)	Inadequate Guardianship	Unsubstantiated
047872 - Deceased Child, Male, 3 Mons	047874 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
047872 - Deceased Child, Male, 3 Mons	047874 - Father, Male, 35 Year(s)	Lack of Medical Care	Substantiated
047937 - Sibling, Female, 2 Year(s)	047873 - Mother, Female, 24 Year(s)	Lack of Medical Care	Substantiated
047937 - Sibling, Female, 2 Year(s)	047874 - Father, Male, 35 Year(s)	Lack of Medical Care	Substantiated
047938 - Sibling, Male, 5 Year(s)	047874 - Father, Male, 35 Year(s)	Lack of Medical Care	Substantiated
047938 - Sibling, Male, 5 Year(s)	047873 - Mother, Female, 24 Year(s)	Lack of Medical Care	Substantiated
047939 - Sibling, Male, 1 Year(s)	047873 - Mother, Female, 24 Year(s)	Lack of Medical Care	Substantiated

047939 - Sibling, Male, 1 Year(s)	047874 - Father, Male, 35 Year(s)	Lack of Medical Care	Substantiated
047940 - Sibling, Male, 4 Year(s)	047874 - Father, Male, 35 Year(s)	Lack of Medical Care	Substantiated
047940 - Sibling, Male, 4 Year(s)	047873 - Mother, Female, 24 Year(s)	Lack of Medical Care	Substantiated

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?	☒	☐	☐	☐
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?	☒	☐	☐	☐

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 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:
Initially, the SM and SF declined offered services. ACS sought court intervention and the court ordered the SS to remain in the parents care with COS.

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?
☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/06/2018	There was not a fact finding	There was not a disposition
Respondent:	047874 Father Male 35 Year(s)	
Comments:	ACS filed the petition due to ACS' concerns around the sleeping arrangements, the SM and SF's substance use, untreated mental health issues and failure to ensure minimum degree of care to the SS.	

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
06/06/2018	There was not a fact finding	There was not a disposition
Respondent:	047873 Mother Female 24 Year(s)	
Comments:	ACS filed the petition due to ACS' concerns around the sleeping arrangements, the SM and SF's substance use, untreated mental health issues and failure to ensure minimum degree of care to the SS.	

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 declined funeral/burial funds as a relative made arrangements. The family completed PPRS intake with New York Foundling agency for case management and coordination of 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 were seen and forensically interviewed at the Bronx CAC.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

The SM was known to the SCR and ACS in two reports dated 6/2/12 and 2/13/15. The 6/2/12 report included the allegations of IG and PD/AM of the 5-year-old SS by the SM. The report was indicated.

The 2/13/15 report included the allegations of IG and XCP of the 2-year-old SS by the SM. The report was unfounded.

The SF had no role in four CPS investigations; 3/11/08, 9/7/08, 8/12/10 and 6/2/12. The SF was listed as a subject in a report dated 2/13/15. ACS unsubstantiated the allegations of IG and XCP of the 2-year-old SS by the SF.

The PA had no known SCR history as a subject.

Known CPS History Outside of NYS

The family had 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:	Timeliness of completion of FASP

Summary:	The initial FASP was due 7/1/18. ACS completed the initial FASP on 8/17/18. The initial FASP was not completed within the required timeframe.
Legal Reference:	18 NYCRR428.3(f)
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.

Preventive Services History

During the 6/2/12 investigation, ACS opened a preventive services case for the SM's family on 7/13/12. The 2/24/16 FASP reflected the SM received parenting skills, monitoring of educational and vocational needs, drug treatment and counseling, developmental assessments of the children and assistance with entitlements. According to the 2/24/16 FASP, the family unit was stable and it was appropriate to close PPRS with Cardinal McCloskey agency. On 10/21/15, the CP requested a random drug test and the test result was negative for all substances. The SM submitted documentation regarding the CHN's medical reports. On 12/24/15 the family relocated to reside with the PGM out of New York State. ACS closed the services case on 4/15/16.

A service case was opened on 10/22/05 involving the PA. The case was closed on 2/28/06. The PA was involved in a COI in which a service case was opened on 11/9/06 and closed on 1/8/07. The PA was known in ADVPO service cases, which were opened on 2/13/07 and 2/3/11, respectively. The cases were closed on 3/1/07 and 11/9/11, respectively.

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