## Report Identification Number: NY-18-089

**Prepared by: New York City Regional Office**

**Issue Date: Mar 08, 2019**

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 **Jurisdiction:** New York **Date of Death:** 09/06/2018
**Age:** 4 month(s) **Gender:** Male **Initial Date OCFS Notified:** 09/07/2018

### Presenting Information

On 9/6/2018, the SCR registered two reports alleging that at approximately 4:00 P.M., the mother placed the SC in the crib to sleep. The mother checked the SC at approximately 7:00 P.M. and found him unresponsive. The mother alerted the shelter staff who called 911 at approximately 7:50 P.M. EMS and NYPD responded to the scene at approximately 7:51 P.M. and began CPR on the SC; however, they were unsuccessful in reviving the SC. The SC was transported to the hospital where he was pronounced dead at 8:26 PM. The SC was an otherwise healthy child with no known medical issues that may have contributed to his death. The father was not present and had an unknown role.

### Executive Summary

The SC was 4 months old when he died on 9/6/18. The autopsy report listed the cause of death as bronchopneumonia complicating viral upper respiratory tract infection and the manner of death was deemed natural.

At the time of death, the SC resided with his mother in a family shelter since 5/31/18. Prior to entering the shelter system, the mother resided with a friend on and off for several years. After a verbal altercation in May 2018, the mother decided not to return to the friend's home. According to the mother, she and the SC's father separated during the initial phase of her pregnancy. Therefore, he had no contact with the SC. The mother provided inconsistent accounts about the father's whereabouts.

ACS referred the family for PPRS with the Children's Aide Society (CAS) as a result of an unfounded report dated 5/29/18. ACS' decision to refer the family for services was due to the mother's recent entry into the shelter system because she was experiencing difficulty with securing housing stability, opening a public assistance case, obtaining day care and securing employment. The mother accepted the services on 8/27/18; however, due to the SC's unforeseen death on 9/7/18, no services were provided.

On 9/7/18, the SCR registered two reports concerning the death of the SC. The allegations of the report were DOA/Fatality and IG of the SC by the mother.

According to ACS' investigation, the mother placed the SC to sleep in his crib at approximately 5:00 P.M. and when she checked the SC at 7:00 P.M., he was unresponsive. The mother left her room with the SC to get help from the shelter staff who called 911 at 7:15 P.M. and administered CPR. When EMS and the NYPD responded to the case address, resuscitation efforts continued and the SC was transported to Harlem Hospital where he was pronounced dead at 8:26 P.M.

ACS initiated the investigation timely and confirmed the mother had no other children. The mother provided inconsistent accounts regarding the father's whereabouts. Therefore, no Notice of Existence (NOE) was mailed to him.

ACS made collateral contacts with the shelter and medical staff, ER and the NYPD, and there were no concerns of abuse or maltreatment of the SC by the mother.

ACS offered the mother burial assistance, but she refused the help. ACS also provided information for bereavement and clinical assistance; however, it is unknown whether the mother followed up with these services. After the fatality, the mother did not continue contact with ACS past the month of September 2018.

As of the time of issuance of this report, ACS had not made a determination.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

**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?** N/A

**Explain:**
N/A

**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:**
N/A

### Required Actions Related to the Fatality

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

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 09/06/2018 **Time of Death:** 08:29 PM

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

**County where fatality incident occurred:** New York

**Was 911 or local emergency number called?** Yes

**Time of Call:** 07:51 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:**

- [x] 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:** 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 | 4 Month(s) |
| Deceased Child's Household | Father | No Role | Male | 28 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 22 Year(s) |

## LDSS Response

ACS interviewed the medical staff from Harlem Hospital and learned that the SC arrived at the hospital at 8:00 P.M., and was pronounced dead at 8:26 P.M. The mother reported she placed the SC in his crib on his back for a nap. At 7:00 P.M., the mother checked the SC and found him unresponsive and lying face down. The medical staff noted the mother was visibly distraught over the death of the SC. The staff indicated the SC had no suspicious marks or bruises on his body. The NYPD found no criminality surrounding the death of the SC.

The shelter staff stated that at the time of the incident, the mother was holding the SC in a panic and the security staff began to administer CPR. The staff stated someone called 911 and EMS continued CPR upon arrival. The staff noted the SC appeared unresponsive when he was transported to the hospital. The staff stated the mother was distraught over the SC's death. The staff had no concerns about the care the mother provided to SC. The mother's room was deemed a crime scene.

The ME informed ACS the preliminary findings of the autopsy revealed the SC had no injuries; however, there were several areas of bowel intussusception.

ACS contacted the Gouverneur Hospital's Pediatrics Clinic and learned the mother came to the walk-in clinic with the SC on 5/10/18. The mother reported she had taken the SC to the ER at another hospital 1 or 2 days prior because he was experiencing difficulty breathing. The SC was examined and it was determined the SC's lungs were clear. However, the mother did not wait for the pediatrician to see the SC. The mother returned with the SC on 5/21/18 for his vaccination, and during this visit the mother did not express any concerns about the SC's feeding or pain.

According to ACS' interviews with the mother, on 9/6/18, she fed the SC at approximately 4:00 P.M. then placed him in his crib for a nap. The mother said she checked the SC at 7:00 P.M. and found him faced down and unresponsive. The mother reported the SC had no problems with his appetite or bowel movements; and there was nothing wrong with him.

The mother reported she was not using any alcohol or substances prior to the SC's death. The mother provided inconsistent information about the SC's father as she said he was incarcerated and later provided contact information. There was no documentation to reflect any effort to contact the alleged father.

ACS completed a home assessment. The mother occupied a small studio that included a crib and twin-size bed. A shower was located outside the room to share with other residents. The mattress for the crib had been confiscated on 9/8/18 by the ME. There were operable smoke and carbon monoxide detectors. ACS observed adequate provisions for the SC such as: clothing, formula and diapers. There were clothes and food strewn throughout the floor, a roach infested dorm size refrigerator and a small air conditioner. ACS documented the room smelled like "smoke" and there were cigarettes in the crib and on a dresser. The Specialist contacted the case manager at the shelter regarding the conditions of the mother's room. ACS learned that this case manager had not completed any inspection of the mother's room.

ACS inquired about the SC's health prior to his death as the ME's preliminary results noted the SC had a bowel intussusception. The mother indicated she had been feeding the SC regular 1% milk because she had no money to buy formula and no Women, Infant, Children (WIC) checks. The mother said she was not aware she needed to recertify by 8/30/18. The mother stated the SC had diarrhea and that his bowel movements were watery. The mother did not say how long the SC had these symptoms. On 9/14/18, ACS discussed this matter with the ME and was informed that the change of milk would not have caused the SC's death.

At the time of issuance of this report, ACS had not made a determination.

## 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 |
|---|---|---|---|
| 047608 - Deceased Child, Male, 4 Mons | 047609 - Mother, Female, 22 Year(s) | Inadequate Guardianship | Pending |
| 047608 - Deceased Child, Male, 4 Mons | 047609 - Mother, Female, 22 Year(s) | DOA / Fatality | Pending |

## CPS Fatality Casework/Investigative Activities

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **All children observed?** | | | X | |
| **When appropriate, children were interviewed?** | | | X | |
| **Alleged subject(s) interviewed face-to-face?** | X | | | |
| **All 'other persons named' interviewed face-to-face?** | | | X | |
| **Contact with source?** | X | | | |
| **All appropriate Collaterals contacted?** | | X | | |
| Family Members | | X | | |
| **Was a death-scene investigation performed?** | X | | | |
| **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)?** | | | X | |
| **Coordination of investigation with law enforcement?** | X | | | |
| **Did the investigation adhere to established protocols for a joint investigation?** | X | | | |
| **Was there timely entry of progress notes and other required documentation?** | | X | | |

**Additional information:**

24 - There were two open fatality reports and progress notes were not entered simultaneously. For instance, in February, one report included notes up to September 2018 and the other December 2018.

## Fatality Safety Assessment Activities

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Were there any surviving siblings or other children in the household?** | | X | | |

## Legal Activity Related to the Fatality

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

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

| Services | Provided After Death | Offered, but Refused | Offered, Unknown if Used | Not Offered | Needed but Unavailable | N/A | CDR Lead to Referral |
|---|---|---|---|---|---|---|---|
| **Bereavement counseling** | | | X | | | | |
| **Economic support** | | | | | | X | |
| **Funeral arrangements** | | | X | | | | |
| **Housing assistance** | | | | X | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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:**
There were no other children or surviving siblings in the household at the time of the incident.

**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?** N/A
**Explain:**
There were no surviving children in the home.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** N/A
**Explain:**
The mother had no other children. In response to the fatality, ACS offered financial assistance for the burial/funeral cost expensed, but the mother refused.

## 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?** | N/A |
| **Was the child acutely ill during the two weeks before death?** | No |

### 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) |
|---|---|---|---|---|---|
| 05/29/2018 | Deceased Child, Male, 1 Months | Mother, Female, 22 Years | Inadequate Food / Clothing / Shelter | Unsubstantiated | Yes |
| | Deceased Child, Male, 1 Months | Mother, Female, 22 Years | Inadequate Guardianship | Unsubstantiated | |

**Report Summary:**
The SCR registered a report and a duplicate alleging the mother had a mental health history, was behaving erratically and was not receiving treatment. There were concerns about the mother not having stable housing or adequate provisions for the 1-month old SC.

**Report Determination:** Unfounded | **Date of Determination:** 07/26/2018

**Basis for Determination:**
ACS unsubstantiated the allegations of IF/C/S and IG of the SC by the mother without completing a thorough investigation. ACS cited the mother had not failed to meet the basic minimum standard of care for the SC that would result to “harm or imminent danger of harm.” ACS also cited that the mother had not failed to meet the SC’s need for shelter, food or adequate clothing.

**OCFS Review Results:**
NYCRO’s review found ACS failed to complete a thorough investigation as the allegations in the narrative of the report were not fully explored. The MGM and the mother’s roommate expressed concerns about the mother’s ability to care for the SC and her erratic behavior. However, there was no effort to review the mother’s history as a foster child to explore any history of erratic behavior or mental health needs. Supervisory directives were either not related to the household composition or were not followed. Basic guidance for proper documentation, contact with the father and relevant collateral was not provided.

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

**Issue:**
Appropriateness of allegation determination

**Summary:**
ACS' determination narrative did not contain specific information to the case circumstance to properly support their decision.

**Legal Reference:**
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

**Action:**
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Failure to provide notice of report
**Summary:**
A Notice of Existence was not issued to the SC's father.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Timely/Adequate Seven Day Assessment
**Summary:**
ACS selected safety factors, but did not explain how they impacted negatively on the mother's ability to properly care, supervise or protect the SC.
**Legal Reference:**
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
**Action:**
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Adequacy of Progress Notes
**Summary:**
The progress notes were not clear and concise. There were no details of the condition of the home during visits or details of the SC's sleeping accommodation at each visit. The supervisory notes reflected directives for the Specialist to make collaterals with the "children's" school, but the mother had no school age children.
**Legal Reference:**
18 NYCRR 428.5
**Action:**
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Failure to provide safe sleep education/information
**Summary:**
ACS documented the SC had a crib in the shelter, but did not provide a description of the crib or document any discussion of safe sleep practices.
**Legal Reference:**
13-OCFS-ADM-02
**Action:**
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Overall Completeness and Adequacy of Investigations

**Summary:**
ACS did not complete a thorough investigation as the issue concerning the mother's untreated mental illness was not explored. ACS noted the family had no previous history; however, CONNECTIONS notes the mother was in foster care and had been discharged on 7/21/16. There was no review of services of her placement history to explore the allegation of mental illness.

**Legal Reference:**
SSL 424.6 and 18 NYCRR 432.2(b)(3)

**Action:**
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Adequacy of Risk Assessment Profile (RAP)

**Summary:**
The adequacy of the RAP is unclear as the questions listed in the template were not properly explored.

**Legal Reference:**
18 NYCRR 432.2(d)

**Action:**
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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

The mother had no CPS history as a subject during this period.

### Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

## 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:** 08/08/2018

**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:** 08/08/2018

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

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Did the service provider(s) comply with the timeliness and content requirements for progress notes?** | ☒ | ☐ | ☐ | ☐ |
| **Did the services provided meet the service needs as outlined in the case record?** | ☐ | ☐ | ☒ | ☐ |

| | | | | |
|---|---|---|---|---|
| Did all service providers comply with mandated reporter requirements? | ☒ | ☐ | ☐ | ☐ |
| 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? | ☐ | ☒ | ☐ | ☐ |

## Casework Contacts

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice? | ☒ | ☐ | ☐ | ☐ |

## Services Provided

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| 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? | ☐ | ☐ | ☒ | ☐ |
| Were services provided to parents as necessary to achieve safety, permanency, and well-being? | ☐ | ☐ | ☒ | ☐ |

## Family Assessment and Service Plan (FASP)

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| Was the most recent FASP approved on time? | ☒ | ☐ | ☐ | ☐ |
| 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:**
ACS made the joint home visit with PPRS on 8/27/18 and the mother signed the application for services. However, the SC died on 9/7/18.

## Preventive Services History

According to NYCRO's review of the family's circumstances, at the time of the SC's death the mother had signed for PPRS on 8/27/18. The mother was referred by ACS for PPRS because she had recently entered the shelter system and was experiencing difficulty with securing housing stability, opening a public assistance case, obtaining day care and securing employment. However, the SC died on 9/7/18 and the documentation reflected that the PPRS had only one contact with the mother.

## 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