Child Fatality Report

Report Identification Number: NY-23-033

Prepared by: New York State Office of Children & Family Services

Issue Date: Aug 11, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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:** Kings **Date of Death:** 03/24/2023
Age: 3 year(s) **Gender:** Male **Initial Date OCFS Notified:** 03/24/2023

Presenting Information

An SCR report was received and alleged the 3-year-old subject child was born with Noonan Syndrome, a condition that affected the development of his organs. The parents had a history of not providing the child with adequate medical care. The child was fed through a feeding tube and on more than one occasion and against medical advice, the mother spoon fed the child. The father was aware of the mother spoon feeding the child and failed to intervene. On 3/6/23, the child had trouble breathing and the parents brought him to the hospital. The child developed a lung infection as a direct result of being spoon fed by the mother. The child's condition worsened, and he became septic. On 3/24/23 at 2:46 AM, the child died.

Executive Summary

This fatality report is regarding the death of the 3-year-old male subject child which occurred on 3/24/23. The child resided with the mother, father and two sibling, ages 12 and 11-years-old. At the time of the fatality, the family was homeless and residing in a shelter. The family moved from their country of origin to the United States in February 2022 in order to receive care for the child's complex medical condition.

The Administration for Children's Services (ACS) had an open preventive services case at the time of the child's death. ACS filed a neglect petition against the parents after they failed to follow through with recommended medical appointments for the subject child. The child was temporarily placed in foster care; however, was returned to the parents' custody under court-ordered supervision. The parents were court-ordered to engage with medical preventive services and comply with all of the child's medical appointments and doctor's recommendations.

The child was born with a genetic condition in addition to other complex medical issues. As a result of the child's condition, he was required to be fed through a nasogastric tube. The mother was non-compliant with the child's feeding procedures, and often took the tube out and bottle and spoon-fed the child. On 3/6/23, the child was hospitalized due to an infection as a result of the mother's actions. While hospitalized, it was determined the child needed to have a gastrostomy feeding tube placed. The mother was not agreeable to the procedure. The mother eventually agreed to allow for the procedure; however, the child contracted a virus while hospitalized and became ill before the surgery could be completed. The child went into multisystem organ failure and died at the hospital.

An autopsy was not completed and there was no criminality found in regard to the death of the subject child. It was determined by the hospital that the child's death was due to septic shock related to his contraction of norovirus.

ACS determined the allegations with the information provided by hospital staff, medical records, and an internal medical consultation. It was determined that the parents were aware of the child's chronic health issues and the importance of him receiving his nutrition through his feeding tube. Despite this knowledge, the tube was removed while the child was in the care of the parents, resulting in an infection and hospitalization. ACS substantiated Lack of Medical Care and Inadequate Guardianship against the parents. The allegations of DOA/Fatality and Malnutrition, Failure to Thrive were unsubstantiated. ACS documented several conversations with medical personnel, in which it was determined the death of the child could not be attributed to the parents' actions or inactions, nor was there medical evidence to support that the child's death resulted from the reason he was admitted to the hospital for treatment.

The family was offered funeral assistance and bereavement counseling; however, the mother declined services on behalf

of the family. The family relocated to another state following the death. ACS virtually assessed their new residence. The mother enrolled the siblings in school. The siblings did not have any medical conditions and the derivative neglect petitions related to the siblings were withdrawn. The CPS investigation was indicated and closed on 6/5/23.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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

Explain:

ACS gathered information related to the fatality and made an appropriate determination of the reported allegations.

Was the decision to close the case appropriate? Yes

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:

The closure of the CPS investigation and preventive services case was appropriate, as all required casework activity was completed. The petitions in relation to the siblings were withdrawn and the family moved out of the state.

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: 03/24/2023 **Time of Death:** 02:46 AM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

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

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	3 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)

LDSS Response

ACS became aware of the child’s hospitalization when an SCR report was received on 3/13/23 regarding the parents’ uncooperativeness with medical staff and the child’s feeding procedures. ACS began monitoring the child’s condition. The child contracted a virus, and in conjunction with his fragile medical status, he died as a result. An SCR report was made the same day regarding the death. ACS immediately began gathering information from medical collaterals and law enforcement and assessed the safety of the siblings.

ACS attempted contact with the family following the fatality. The parents were uncooperative with ACS and the siblings minimally engaged in their interviews. The information obtained regarding the death and the child’s medical condition was gathered from the hospital staff and pediatrician.

Through a review of medical records and contact with hospital personnel, ACS gathered information regarding the parents’ alleged noncompliance with the child’s medical care. In July 2022, the child presented to the emergency room

with difficulty swallowing and problems with eating. The child required a nasogastric feeding tube. The feeding tube was inserted in August 2022 and after the parents received the necessary medical training, the child was discharged home with the feeding tube in place. The hospital offered the child a visiting nurse and the mother declined. The child was referred to several specialists and to medical preventive services through ACS. The parents refused to cooperate with ACS and there were ongoing concerns regarding the child not receiving the necessary follow-up medical care. ACS documented observation of the child's feeding tube during a routine home visit in September 2022; however, no other contacts documented by ACS reflected if the feeding tube remained in place.

ACS filed a neglect petition against the parents and the child was removed and placed in foster care on 11/5/22. On 11/17/22, the child was returned to the parents' care under court-ordered supervision. The parents were required to bring the child to his medical appointments and engage with medical preventive services. The mother continued to refuse to provide confirmation that the child was seeing the recommended specialists and the referral with medical preventive was closed due to lack of contact. The mother cited that there was an issue with her insurance, resulting in the delay of specialist appointments; however, the issue was rectified by ACS as they called the pediatrician and requested referrals be made to places that accepted the child's insurance. The child had specialist appointments scheduled for late March 2023.

On 3/6/23, the child was admitted to the hospital due to breathing complications. The child's feeding tube was not in place and the mother reported the child's pediatrician advised her she could remove it. The pediatrician reported though he was aware of the child's medical conditions, he was unaware the child had a feeding tube, nor did he advise the mother to remove it. Though there was concern that the parent's disagreement with the gastrostomy feeding tube insertion resulted in an extended hospitalization, medical records revealed the delay in insertion was due to the child having a persistent fever. On the evening of 3/23/23, the child's condition declined: his fever spiked, he had episodes of diarrhea, decreased energy, elevated white blood cells, and was in respiratory distress and septic shock. On 3/24/23 the child died as a result of this condition.

The siblings had no reported medical conditions. They were in receipt of medical care and were last at the pediatrician in November 2022. The family relocated to another state following the death. The siblings and home were assessed virtually and there were no concerns. ACS confirmed the siblings were enrolled in school. Fatality-related services were offered and the mother declined on behalf of the family.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: NYC does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064392 - Deceased Child, Male, 3 Yrs	064393 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated

064392 - Deceased Child, Male, 3 Yrs	064393 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
064392 - Deceased Child, Male, 3 Yrs	064393 - Mother, Female, 36 Year(s)	Lack of Medical Care	Substantiated
064392 - Deceased Child, Male, 3 Yrs	064393 - Mother, Female, 36 Year(s)	Malnutrition / Failure to Thrive	Unsubstantiated
064392 - Deceased Child, Male, 3 Yrs	064394 - Father, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
064392 - Deceased Child, Male, 3 Yrs	064394 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
064392 - Deceased Child, Male, 3 Yrs	064394 - Father, Male, 37 Year(s)	Lack of Medical Care	Substantiated
064392 - Deceased Child, Male, 3 Yrs	064394 - Father, Male, 37 Year(s)	Malnutrition / Failure to Thrive	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
Explain: The 24-hour safety assessment reflected a safety decision 3 due to the pending derivative neglect petitions regarding the siblings. At the time of the 7-day safety assessment, it was determined there were no concerns for the siblings' safety and they were not in impending or immediate danger. At the time of the 30-day safety assessment, the whereabouts of the family were not known. ACS documented diligent efforts to locate them.				

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	☒	☐	☐	☐

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☒	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

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? No
Explain:
The parents were offered fatality related services on behalf of the siblings and declined them.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were offered services related to the fatality and declined them.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? Yes

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)
03/13/2023	Deceased Child, Male, 3 Years	Mother, Female, 36 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 3 Years	Mother, Female, 36 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 36 Years	Malnutrition / Failure to Thrive	Unsubstantiated	
	Deceased Child, Male, 3 Years	Father, Male, 37 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 3 Years	Father, Male, 37 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 3 Years	Father, Male, 37 Years	Malnutrition / Failure to Thrive	Unsubstantiated	

Report Summary:
An SCR report was received and alleged that the child had a complex medical history. It was necessary for the child to have a feeding tube replacement. The parents needed to complete a course of antibiotics training and they were refusing to finish the course. The child needed a feeding tube to get nourishment. The mother pulled the tube out and fed him without it, creating a concern for a bad infection or worst-case scenario the child could die from failure to thrive or infections. The mother was uncooperative with the hospital staff.

Report Determination: Indicated | **Date of Determination:** 05/13/2023

Basis for Determination:
ACS substantiated LMC and IG against the parents. The child was hospitalized and required surgery to insert a feeding tube. Medical staff explained the necessity of the child having surgery; however, the parents refused the surgery. In addition, it was learned that the parents were advised to feed the child via his tube but the parents discontinued feeding via the tube and spoon and bottle fed the child. M/FTTH was unsubstantiated as the hospital reported the child was not malnourished.

OCFS Review Results:
ACS completed a home visit, conducted a CPS history check, gathered pertinent documentation, conferenced with their legal department and accessed family court when necessary, spoke to medical collaterals, and offered services. The child died during the investigation and a subsequent report was made regarding the fatality. The family was offered services in relation to the death but the mother declined. The family relocated to another state and the investigation was closed.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/12/2022	Deceased Child, Male, 3 Years	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Deceased Child, Male, 3 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Male, 11 Years	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 11 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 10 Years	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 10 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 3 Years	Father, Male, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 3 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 11 Years	Father, Male, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 11 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 10 Years	Father, Male, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 10 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 3 Years	Mother, Female, 35 Years	Lack of Medical Care	Substantiated
Sibling, Male, 11 Years	Mother, Female, 35 Years	Educational Neglect	Substantiated
Sibling, Female, 10 Years	Mother, Female, 35 Years	Educational Neglect	Substantiated

Report Summary:
An SCR report alleged the subject child was born with a genetic disorder called Noonan Syndrome. As a result, the child was required to be fed through a feeding tube. The mother was aware that the child was required to be fed through a feeding tube, yet, when medical supplies were delivered to the family's residence, the mother refused the order and sent the supplies back. The supplies were then provided to the mother at the hospital, and she refused them again. If the child was not fed through the feeding tube, he would be unable to obtain the nutrients that were needed for his daily growth.

Report Determination: Indicated | **Date of Determination:** 10/12/2022

Basis for Determination:
ACS substantiated LMC and EdN as they determined the evidence indicated the mother refused medical equipment and nutrition sent from the hospital. Since being discharged from the hospital, there were no records indicating that the child was receiving services for recommended treatment. In addition, the evidence indicated that up until the case closing, the siblings were not enrolled in school. ACS unsubstantiated the allegations of IG and IF/C/S. ACS observed the shelter in clean conditions and there was food for the children. The children appeared comfortable with the parents and there were no marks or bruises seen on the children's bodies.

OCFS Review Results:
ACS thoroughly investigated the allegations by interviewing the family and medical collaterals. ACS identified concerns for the family and collaborated with service providers to meet the needs of the family. The mother was not cooperative and refused all services provided to her and declined to provide any information to ACS. ACS opened a preventive services case for the mother and the concerns continued to be monitored at the time the CPS investigation was closed.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/19/2022	Deceased Child, Male, 3 Years	Mother, Female, 35 Years	Inadequate Guardianship	Far-Closed	No

Report Summary:
An SCR report was received and alleged that the child had been hospitalized since 7/10/22. The child had been in other hospitals because of his health ailments. The child was on a regulated treatment program with medication. The mother was not giving the medicines to the child and was not receptive to his treatment plan. In addition, the mother attempted to remove the child from the hospital and take him home which would have caused significant risk for him due to his deregulated breathing. The mother failed to recognize the level of care needed for the child and compromised his safety by her actions.

OCFS Review Results:
Upon receipt of the SCR report, ACS explained Family Assessment Response to the family, completed a home visit, offered services, and completed assessment tools. ACS spoke to medical collaterals regarding the child's condition. During the case, the mother obtained an attorney and refused contact with ACS. Hospital staff expressed concern for the mother's refusal to provide them with necessary information and for her refusal of necessary medical equipment for the child. ACS re-tracked the case to an investigation due to the concerns.

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

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

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

Known CPS History Outside of NYS

The family previously resided in New Jersey and Texas. Texas reported no child welfare history with the family. New Jersey had 3 unfounded referrals regarding the family between March and June 2022.

On 3/24/22 a referral was received with concerns that the family was homeless. During that time, the family was receiving assistance through a community-based services agency. The agency assisted in obtaining glasses for the child, medical insurance, and assisted with transportation to and from appointments. The agency provided temporary housing for the family at a hotel. Collateral contacts reported no concerns for the children. All three children were up to date with immunizations and the child was referred to specialists.

On 5/26/22 a referral was received due to concerns that the family was using a hotplate in the hotel room.

On 6/14/22 a referral was received regarding the father as it was reported that he engaged in a physical altercation with a hotel staff that led to his arrest. The father had the child in his hands when the altercation occurred.

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: 08/12/2022

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: 08/12/2022

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?	☒	☐	☐	☐

Explain:
ACS attempted to provide court-ordered medical preventive services but the parents refused and the referral was closed. The record did not reflect family court was accessed about the refusal.

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: The family was court ordered to engage with medical preventive services; however, the mother refused to participate.				

Preventive Services History

A preventive services case was opened in August 2022, following concerns that the parents were not complying with the child's medical care. Between August and November 2022, the parents refused to provide information to confirm the child was in receipt of necessary medical care due to his health conditions. On 11/1/22 a child safety conference was held resulting in the decision to file a neglect petition for a remand of the child. The court granted ACS's request. On 11/7/22, the judge granted extended visits. On 11/17/22, the child was returned to the parents' custody with terms that the mother sign releases for the children, agree to medical preventive, follow medical recommendations, take the child to all appointments, and comply with ACS supervision. The mother refused to cooperate with medical prevention and the referral was closed. With the exception of a home visit in September 2022, it was unclear if the child's feeding tube remained in place, as ACS did not document an observation of it or a conversation about it during subsequent visits, despite the concern that the mother was not using it. At the time of the child's death, he had not attended a specialist appointment. Following the death of the child, the neglect petitions were withdrawn and the preventive services case was closed.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☒Yes ☐No

Issue:	Failure to Complete a Plan Amendment
Summary:	Though a plan amendment was completed, it was submitted and approved late on 5/24/23.
Legal Reference:	18 NYCRR 428.7
Action:	ACS will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Foster Care Placement History

On 11/01/22 a child safety conference was held resulting in the decision to file a neglect petition for a remand of the child. The court granted ACS's request. On 11/7/22, the judge granted extended visits. On 11/17/22, the child was returned to the parents' custody.

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:**
11/02/2022	There was not a fact finding	Withdrawn
Respondent:	064393 Mother Female 36 Year(s)	
Comments:	ACS filed a neglect petition against the parents, resulting in the child being remanded to ACS custody. On 11/7/22, the judge granted the mother extended visits. Subsequently, the case was settled on 11/17/22 with terms that the mother signed releases for the children, agreed to medical preventive, followed recommendations, take the child to all appointments, and comply with ACS supervision. The petitions were withdrawn following the death.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
11/02/2022	There was not a fact finding	Withdrawn
Respondent:	064394 Father Male 37 Year(s)	
Comments:	ACS filed a neglect petition against the parents, resulting in the child being remanded to ACS custody. On 11/7/22, the judge granted the mother extended visits. Subsequently, the case was settled on 11/17/22 with terms that the mother signed releases for the children, agreed to medical preventive, followed recommendations, take the child to all appointments, and comply with ACS supervision. The petitions were withdrawn following the death.	

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