Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-090

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

Issue Date: Feb 29, 2024

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
Age: 1 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 09/23/2023
Initial Date OCFS Notified: 09/26/2023

Presenting Information

The New York City Administration for Children's Services (ACS) completed an OCFS-7065 Agency Reporting Form on 9/26/23, after learning of the 1-month-old subject child's death. There was an open FAR case at the time of the death due to concerns for the condition of the home. After the death, an investigation was opened due to ACS determining the case circumstances no longer met their FAR criteria.

Executive Summary

On 9/25/23, ACS was notified by the mother that the 1-month-old female subject child passed away on 9/23/23. ACS had an open FAR case with the family that began on 9/19/23. The FAR case was opened due to concerns regarding the condition of the family's residence. On 9/26/23, ACS determined the case no longer met the criteria for FAR due to the subject child's death. The FAR case was closed and a CPS investigation was initiated with the allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter against the parents.

Prior to the subject child's death, she resided with her mother, father and two surviving siblings, ages 10 and 8 years. ACS assessed the safety of the surviving siblings and determined they were safe in their mother's care. The 10 and 8-year-old surviving siblings' father was not identified and his whereabouts were unknown.

ACS learned on 9/23/23, the mother brought the subject child to the hospital following an incident in which the subject child woke up at 4AM, was unable to be consoled and was breathing irregularly. Upon arriving at the hospital, the subject child appeared to be recovering; however, shortly after, the subject child went into cardiac arrest. Hospital staff attempted to revive the subject child without success.

ACS communicated with the medical examiner and learned an autopsy was performed and that the death could be ruled as a natural cause due to the congenital heart disease. The final autopsy report was not received and the official manner of death was pending.

The record reflected that ACS offered bereavement services to the parents; however, it remained unclear if they utilized the services. During the investigation it was determined that death was due to the child's medical condition therefore, there was no SCR report made regarding the fatality. The allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter were unsubstantiated due to ACS determining that the living conditions were appropriate.

PIP Requirement
For citations identified in historical cases, ACS will submit a PIP to the New York City Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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:**
  - **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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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:
There was no SCR report regarding the fatality; therefore, the completion of safety assessment tools was not required. Case documentation did not reflect any reasons for the case to remain open with services.

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: 09/23/2023 **Time of Death:** Unknown

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? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	No Role	Female	1 Month(s)
Deceased Child's Household	Father	No Role	Male	35 Year(s)
Deceased Child's Household	Mother	No Role	Female	45 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Other Household 1	Grandparent	No Role	Female	81 Year(s)

LDSS Response

Upon receiving the information from the BM that the SC was deceased ACS closed their FAR case and an investigation was opened alleging the same concerns regarding the home. ACS initiated their investigation within 24 hours and spoke with the medical examiner. ACS assessed the SSs to be safe in the care of their mother.

ACS interviewed the mother and father; however, the father did not provide any information relevant to the fatality. During their interviews, ACS learned that on 9/23/23, the SC had an uneventful day. The BM fed the SC, and the SC went to sleep as normal and woke up for a feeding. The SC woke up again around 4AM and was crying. The SM attempted to give the SC a bottle but she would not take it. The SC started to pass gas but continued to cry. The BM felt something was not right and told the BF they had to bring the SC to the hospital. The BF confirmed this information by nodding to ACS. The parents took the SC to the hospital. At the hospital the SC's heart rate varied from 120 to 60. A breathing tube was used and chest compressions were performed. Eventually the SC's heart stopped.

ACS learned that the SC was in the ICU for 26 days after birth. ACS learned that the SC was seen on 8/29/23 and on 9/21/23 by the primary care provider and she was gaining weight and appeared to be thriving.

ACS spoke with the source, contacted the DA's office, and submitted a request for criminal records. The SSs were spoken with but not interviewed regarding the SC's health or circumstances leading to her death. ACS did not speak with the subject child's primary care provider or cardiologist. The SC was treated at the hospital but ACS did not speak with the hospital staff.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☒	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
This was not an SCR-reported fatality; therefore, certain investigative activities were not required.

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: As there was no SCR report surrounding the fatality, the completion of safety assessments was not required; however, ACS documented an assessment of the siblings' safety following the death and there were no concerns.				

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? Yes
Explain:
ACS provided information regarding bereavement services to the parents.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided information regarding bereavement services to the parents.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

09/26/2023	Deceased Child, Female, 1 Months	Mother, Female, 45 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Female, 1 Months	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 10 Years	Mother, Female, 45 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 10 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Years	Mother, Female, 45 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 8 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 1 Months	Father, Male, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 1 Months	Father, Male, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 10 Years	Father, Male, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 10 Years	Father, Male, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Years	Father, Male, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 8 Years	Father, Male, 35 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received and alleged the living conditions posed a health and safety hazard to all three children. The home was dirty and had bugs; the parents were aware and allowed the children to continue residing in unsanitary conditions.

Report Determination: Unfounded | **Date of Determination:** 11/22/2023

Basis for Determination:
ACS unsubstantiated the allegations of IG and IF/C/S against the BM and BF regarding the SC and both SSs due to a lack of a fair preponderance of evidence. ACS made numerous visits to the home and always found it to be neat and clean with no safety concerns. The home was appropriate. The death was not a result of abuse or maltreatment, and it was determined the child died of natural causes.

OCFS Review Results:
ACS initiated the investigation within 24 hours, contacted the source and reviewed CPS history. ACS notified the DA and the CAC about the fatality. ACS interviewed the mother about events leading up to the SC's death. The SSs were seen and spoken with but not interviewed. The MGM who was initially listed on the FAR case was not engaged as a collateral. Some collateral contacts were attempted however, not enough information was gathered from the SC's medical providers, including primary care, cardiology and the hospital where the SC passed away. ACS assessed the safety of both homes prior to making a determination.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
ACS did not attempt to gather the SSs BF's information or contact him, did not gather information from the SC's medical

providers, and inaccurately documented information in the RAP.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

ACS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved. ACS will adequately document information that is gathered in connections.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

Full interviews were not completed with the CHN to determine the allegations and assess overall safety and risk. Though ACS was notified that the family was moving back into the home with the initial safety concerns. They did not make a visit to the home until a month after the family returned to live there.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

ACS will make an assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation. ACS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/19/2023	Deceased Child, Female, 1 Months	Mother, Female, 45 Years	Inadequate Food / Clothing / Shelter	Far-Closed	Yes
	Deceased Child, Female, 1 Months	Mother, Female, 45 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 10 Years	Mother, Female, 45 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 10 Years	Mother, Female, 45 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 8 Years	Mother, Female, 45 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 8 Years	Mother, Female, 45 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Female, 1 Months	Grandparent, Female, 81 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Deceased Child, Female, 1 Months	Grandparent, Female, 81 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 10 Years	Grandparent, Female, 81 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 10 Years	Grandparent, Female, 81 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 8 Years	Grandparent, Female, 81 Years	Inadequate Food / Clothing / Shelter	Far-Closed	

	Sibling, Male, 8 Years	Grandparent, Female, 81 Years	Inadequate Guardianship	Far-Closed

Report Summary:
An SCR report was received and alleged on an ongoing basis the BM and the MGM failed to ensure a clean and adequate living environment for the children. They had an infestation of flees and various bugs in the home for years. They had several cats in the home that caused a foul odor and were urinating all over the home, including on the couch where the children would sleep. BM failed to provide adequate supervision of the children. While she was working she would leave them in the care of the MGM, who had a medical condition that caused her to leave the home and wander around neighborhood, leaving the children unattended. The MGM had also forgotten to feed the children on multiple occasions.

OCFS Review Results:
ACS initiated their investigation within 24 hours and completed a history review. ACS visited the MGM's home and learned the BM and CHN did not reside there. ACS visited and assessed the family at the address the BM provided. The investigation notes were unclear and some had inaccurate information based on the event dates. The MGM was a subject but was not engaged. The CHN were seen but not asked about allegations and safety and risk. The FLAG was completed but it was unclear how some data was collected. Due to the SC's death the FAR case was closed and reopened as an investigation before further casework could be completed.

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

Issue:
FAR-Overall Completeness/Adequacy of Family Assessment Response

Summary:
Several case notes had information that happened later than the event date. The case record did not reflect discussion regarding FLAG questions. The 7 Day Safety Assessment did not reflect information in the case notes. The safety assessment due at the investigation closing was not completed.

Legal Reference:
18 NYCRR 432.13 (a)(1-4)

Action:
ACS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved. ACS will adequately document information that is gathered in connections.

Issue:
FAR-Failure to Engage the Family

Summary:
There was no documentation of the CHN being engaged or spoken with by ACS. There was no documentation that any attempts were made to contact the MGM, who was a subject of the report. The record did not reflect who participated in the completion of the FLAG with the ACS.

Legal Reference:
18 NYCRR 432.13 (e)(2)(iii)

Action:
Family members will be engaged in discussions whenever possible in an effort to elicit key information surrounding safety and risk. Discussions with all family members will include relevant safety-related questions.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/02/2020	Sibling, Female, 7 Years	Mother, Female, 43 Years	Educational Neglect	Far-Closed	Yes
	Sibling, Female, 7 Years	Mother, Female, 43 Years	Inadequate Guardianship	Far-Closed	

Sibling, Female, 7 Years	Mother, Female, 43 Years	Lack of Medical Care	Far-Closed
Sibling, Female, 5 Years	Mother, Female, 43 Years	Educational Neglect	Far-Closed
Sibling, Female, 5 Years	Mother, Female, 43 Years	Inadequate Guardianship	Far-Closed

Report Summary:
The SCR report alleged that the BM was not sending the children to school. The children had not attended school since the beginning of the school year and as a result missed a total of 27 days. The children had missed significant academic content and were failing. The school exhausted all efforts to engage with the family. The 7-year-old sibling had an Individualized Educational Plan and received counseling in school but was not receiving these services due to missing school.

OCFS Review Results:
ACS began the investigation within 24 hours, a CPS history check was completed, and the source was contacted. The mother was interviewed but no other family members were interviewed. There was no documentation of observations or conversation with the children until 12/8/2023. A 7-day safety assessment was completed, but the investigation determination safety assessment was not. The FLAG was completed late. The concerns were not adequately discussed with the family and collaterals before the closure of the FAR case, and the conclusion narrative conflicted with the information in the case record.

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

Issue:
FAR-Overall Completeness/Adequacy of Family Assessment Response

Summary:
The FAR case was focused solely on the SCR-reported concerns. Not enough information was obtained to determine if the closure of the FAR case was appropriate. Some of the information from the FLAG was not in the progress notes, some progress notes were lacking significant details, and an unrelated home member was never identified.

Legal Reference:
18 NYCRR 432.13 (a)(1-4)

Action:
ACS will comply with OCFS regulations pertaining to required activities in a FAR case.

Issue:
FAR-Failure to Engage the Family

Summary:
There was documentation that the MGM was spoken with but not documentation regarding what was spoken about. The only documentation of ACS speaking with the CHN was ACS asking if they liked school and a school break. Allegations were not addressed with the MGM or the CHN. ACS did not ask the name of the father and did not attempt to send him any notification of the report.

Legal Reference:
18 NYCRR 432.13 (e)(2)(iii)

Action:
Family members will be engaged in discussions whenever possible in an effort to elicit key information surrounding safety and risk. Discussions with all family members will include relevant safety-related questions.

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
Multiple progress notes had information that happened after the note entry date and addendums containing the majority of the note were added over a month later. The progress notes did not reflect how ACS gathered some of the information to complete the FLAG.

Legal Reference:

18 NYCRR 428.5

Action:

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded. Documentation within the FAR case must include caseworker efforts to explore and elicit information pertaining to each area of the Family-Led Assessment Guide (FLAG).

[redacted]

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.

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