Child Fatality Report

Report Identification Number: NY-23-105

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

Issue Date: Mar 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: 2 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 10/26/2023
Initial Date OCFS Notified: 10/26/2023

Presenting Information

On 10/26/23, an SCR report was received that alleged the mother placed the 2-month-old subject child down to sleep in her crib at about 4:00am that day. The mother woke up around 6:00am, checked on the child after she returned from the bathroom, and noticed blood coming from the child's nose. The father picked the child up from the crib and placed the child on an adult bed and the mother called 911 around 6:34am. Law enforcement and EMS arrived at the home and began CPR on the child. EMS transported the child to the hospital where the child was pronounced deceased. The child was an otherwise healthy child, and the mother and father had no explanation for the child's death.

Executive Summary

On 10/26/23, New York City Administration for Children's Services (ACS) received an SCR report regarding the death of the 2-month-old female subject child that occurred on the same day. The report alleged DOA/Fatality and Inadequate Guardianship against the mother and the father regarding the child. At the time of death, the child resided with her mother, father, and the 8 and 3-year-old siblings. At the time of the death, there was an open preventive services case which began on 2/2/23, regarding concerns of domestic violence in the home.

ACS coordinated efforts with law enforcement, completed casework and collateral activity and learned that the child was seen at the pediatrician on 10/25/23, and received 4 immunizations at that visit. The mother reported the child was fussy and crying more than usual and the father noticed the child's leg was swollen where she received immunizations. The child awoke at about 3:00am, and the mother bottle-fed the child formula, interacted with the child and took videos, then placed the child back in the crib to sleep. Around 6:00am, the mother checked on the child in the crib and the child was not breathing. The mother woke the father, and he took the child out of the crib, placed her on the bed, and started CPR while the mother called 911. Emergency Medical Services arrived at the home, took over resuscitative measures and transported the child to the hospital. Hospital staff took over life-saving measures; however, were unsuccessful and the SC was pronounced deceased.

ACS contacted the medical examiner's office and learned an autopsy was performed. The final autopsy report listed the cause of death as sudden unexplained infant death (SUID) with intrinsic factors, and the manner of death was natural. The autopsy report noted postmortem microbiology testing for the child detected Rotavirus A and human rhinovirus/enterovirus. Law enforcement found no criminality regarding the death of the child, no arrests were made, and the criminal investigation was closed.

ACS gathered information surrounding the fatality from law enforcement, the medical examiner, and relatives. ACS offered the family bereavement services and burial assistance. The parents accepted the burial assistance. The father declined bereavement services. The mother and the 8-year-old sibling were previously engaged with community service agencies and continued their involvement with them. ACS made a referral for play therapy for the siblings. The record did not reflect ACS contacted the biological father of the 8yo SS or provided him with a notification letter regarding the report. The pediatrician was not contacted regarding the SC or the SSs. The record reflected one unsuccessful attempt was made to contact hospital staff and EMS. ACS unsubstantiated the allegations in the report and closed the investigation. The preventive services case remained ongoing at the close of the CPS investigation.

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 made an appropriate determination based on the evidence obtained throughout the investigation.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework activity was not commensurate with the case circumstances. There were missed opportunities to gather collateral information from hospital staff, EMS, and the pediatrician. The record did not reflect the father of the 8yo SS was contacted.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	There were missed opportunities to gather collateral information from the pediatrician, hospital staff and EMS. The record reflected one phone call was made to hospital staff and EMS on 11/3/23; however, no follow up attempts were made.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS will obtain information from collateral contacts who may have information relevant to the

	allegations in the report and to the safety of the children.
Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	The record did not reflect efforts to locate, interview, or notify the father of the 8yo SS regarding the SCR report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	ACS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document such interviews, or reasons why an interview was not possible should be documented in progress notes.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/26/2023 **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? Yes
Time of Call: 06:34 AM
Did EMS respond to the scene? Yes
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

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	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

On 10/26/23, ACS received a report regarding the death of the SC. ACS initiated their investigation within 24 hours and coordinated their efforts with LE. ACS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. ACS assessed the safety of the SSs and conducted an initial home visit on 10/26/23.

ACS interviewed the parents regarding the events leading up to the SC's death. The SM reported the SC received 4 immunizations at the pediatrician the day prior to the SC's death, 2 in one leg, 1 in the other leg, and 1 orally. The SM reported the SC was very fussy and crying. The SM denied the SC had a fever and stated there was no swelling around the areas where the SC received the shots. On the day of the fatal incident, the SM fed the SC around 3:00am, and the SC took the formula with no problem. The SM and SF interacted with the SC after she was fed, and the SM took photos and videos of the SC. The SM placed the SC in the crib to sleep and the parents went to sleep. At about 6:00am, the SM woke up and checked on the SC and noticed the SC was not breathing. The SM woke the SF, and he began CPR on the SC while the SM called 911. The SF said he placed two fingers between the child's ribcage and pressed down, then covered the child's nose and mouth with his mouth. The father then flipped the child over his arm and proceeded to hit the child on the back in case there was something stuck in the child's throat. The SF reported that on the day prior to her death, the SC was "cranky", and her leg appeared to be swollen where she received the immunization; however, the SC calmed down and took her feedings well the night prior and the morning of the fatal incident.

ACS and LE interviewed the 8yo SS and he had no information regarding the death of the SC. The 8yo SS reported he was asleep, and that the SF woke him up and told him they had to go. The SSs went with the SF to the hospital and was told the SC had passed away. The 3yo SS was unable to be interviewed due to his age and developmental ability. The siblings appeared well and had no visible marks or bruises. ACS spoke with relatives, and they had no concerns for the SM's care of the children.

ACS spoke with the preventive services caseworker who conducted a home visit the day prior to the death, after the child was seen by the pediatrician. The SM made the caseworker aware the SC had gotten 4 immunizations earlier in the day. The SC was observed to be alert and active; however, the child appeared to be irritable and crying more than usual. The caseworker had no concerns for the SC or the family. ACS spoke with the SM's therapist, who reported there were no concerns for the SM. The SM attended her sessions and was fully engaged in treatment.

ACS contacted collateral sources including LE, the ME, school staff, the SM's therapist, and relatives. The record did not reflect ACS contacted the biological father of the 8yo SS or provided him with a notification letter regarding the report. The pediatrician was not contacted regarding the SC or the SSs. The record reflected one unsuccessful attempt was made to contact hospital staff and EMS; however, there were no follow-up attempts made prior to the case closure. Burial assistance was offered to the parents, and they accepted. The SF declined bereavement services and the SM remained engaged with her community-based services. ACS made a referral for counseling services for the SSs. At the close of the investigation the SSs were deemed as safe, and no criminal charges were brought against either parent. ACS did not find a preponderance of evidence to support the allegations in the report, and appropriately unfounded and closed the investigation. The preventive services case remained open at the close of the CPS investigation.

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)? Yes

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066608 - Deceased Child, Female, 2 Month(s)	066771 - Mother, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
066608 - Deceased Child, Female, 2 Month(s)	066771 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
066608 - Deceased Child, Female, 2 Month(s)	066772 - Father, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
066608 - Deceased Child, Female, 2 Month(s)	066772 - Father, Male, 37 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to

				Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: The family was engaged in preventive services prior to the death of the subject child. Ongoing support was provided following the death.				

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?	☐	☒	☐	☐

Explain as necessary:
There was no removal regarding the surviving siblings.

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
ACS provided Preventive Services to the family prior to and following the death of the subject child. The mother was in receipt of counseling services. The family was referred to community-based services related to the fatality.

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 made a referral for play therapy for the SSs, and the SM accepted on behalf of the children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The father declined bereavement services that were offered by ACS and the mother remained engaged with her counseling services. ACS offered the parents burial assistance and they accepted.

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? 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)
09/01/2023	Sibling, Male, 2 Years	Father, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
A subsequent SCR report alleged on 1/25/23, the SF was under the influence of an illegal substance and physically assaulted the mother. The SF threw a hammer at the mother, and strangled the mother while the then 2yo SS was present in the residence. The 8yo SS was not home when the incident occurred.

Report Determination: Unfounded | **Date of Determination:** 10/20/2023

Basis for Determination:
The SF had been engaged in a batterer's accountability program, engaged in a substance abuse treatment program, and passed multiple drug screens. The SF was allowed to return to the home with a modified OP in place protecting the mother, SC, and SSs. The allegation of Inadequate Guardianship was unsubstantiated against the SF because the specific incident and allegations were previously investigated on 1/25/23. The report was a subsequent report that reiterated the incident that occurred on 1/25/23. The investigation was unfounded and closed, and the preventive services case

remained open.

OCFS Review Results:
The investigation was initiated timely and the source was contacted. The 7-day Safety Assessment was completed timely. Written notice was provided timely. A CPS history check was completed. A home visit was made, and safe sleep recommendations were provided. The record did not reflect the father was made aware of the subsequent report. There were notes in the preventive services case that were not copied into the subsequent report regarding the father.

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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
Although the father was spoken to regarding the preventive services case, the record did not reflect the father was made aware of or interviewed regarding the SCR report dated 9/1/23, on which he was listed as an alleged subject.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:
Case record contains information that is relevant, useful, factual and objective

Summary:
ACS maintained a CPS investigation and an ongoing services case at the same time. Although progress notes can be copied between investigations, maintaining separate records in this case led to fragmented case recording of progress notes.

Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:
ACS records must contain information that is relevant, useful, factual, and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/25/2023	Sibling, Male, 2 Years	Father, Male, 36 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
An SCR report alleged the SF was physically aggressive toward the mother in the presence of the then 2yo SS. The verbal altercation turned into a physical altercation when the SF grabbed the mother by the throat and tried to strangle her, attempted to hit her with a hammer, threw a chair at her, and flipped a table toward her. The then 2yo SS did not sustain any injuries; however, the SS observed the altercation and told the father to stop. The 8yo SS was not home when the altercation occurred.

Report Determination: Indicated | **Date of Determination:** 03/24/2023

Basis for Determination:
The allegation of Inadequate Guardianship was substantiated against the father regarding the then 2yo SS. The father admitted to being the aggressor during the altercation and admitted being under the influence of drugs at the time of the altercation. The father was arrested and charged criminally, and a full stay OP was put in place protecting the SM and the SSs. On 2/3/23, a preventive services case was opened for the family. ACS indicated and closed the CPS investigation on

3/24/23, while the preventive services case remained open.
OCFS Review Results: The record reflected timely completion of case objectives including the investigation initiation, 7-day Safety Assessment, provision of notification letters, and check of CPS history.
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

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

An SCR report dated 10/28/17 was substantiated for the allegations of IG against the SM and the father of the now 8yo SS regarding the 8yo SS.

An SCR report dated 5/20/19 was unsubstantiated for the allegations of IG against the SM and the father of the now 8yo SS and PD/AM against the SS's father regarding the now 8yo SS.

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: 02/03/2023

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?	☐	☒	☐	☐
If not, how many days was it overdue? The most recent required FASP was completed 12 days late. ACS did not complete a plan amendment documenting the status change following the subject child's death.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

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 provided the services.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Failure to Complete a Plan Amendment
Summary:	A plan amendment was not completed following the fatality. The purpose of a plan amendment is to describe/document significant changes in the status of a case and direct a reassessment so that any necessary revisions to the service plan can be made.
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. 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.

Preventive Services History

On 2/3/23, ACS filed an Article 10 Neglect Petition, and an order of supervision and OP were granted. The neglect

petition was filed against the SF as the result of a domestic violence incident in which the SF strangled the SM and threatened her with a hammer in the presence of the then 2yo SS. The mother was 3 months pregnant at the time of the incident. At the time of the death, the preventive services case remained open, as the Article 10 Neglect remained active in Family Court, pending disposition.

Foster Care Placement History

In 2017, a protective services case was opened after an Article 10 Neglect petition was filed against the SM and the father of the now 8yo SS regarding a domestic violence incident that took place in the presence of the now 8yo SS. The SS was removed and placed in the care of a relative. The SS was returned to the SM's care on 8/4/20, and the protective services case was closed on 9/22/21.

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:**
02/03/2023	There was not a fact finding	There was not a disposition
Respondent:	051301 Other	
Comments:	An Article 10 Neglect petition was filed against the father as the result of a domestic violence incident in which the father strangled the mother and threatened her with a hammer in the presence of the then 2yo sibling. The mother was 3 months pregnant at the time of the incident. On 2/3/23, ACS filed an Article 10 Neglect Petition, and an order of supervision and OP were granted. On 8/31/23, the subject child was added to the petition. The Article 10 Neglect remained active in Family Court, pending disposition. The father was granted supervised visitation. On 10/12/23, the OP was modified to reflect that the father would abide by a limited OP on behalf of the non-respondent mother and children. The father was allowed to reside in the home so long as he complied with the order of supervision.	

Have any Orders of Protection been issued? Yes	
From: 01/26/2023	**To:** Unknown
Explain: A full stay-away OP was issued through criminal court against the father on behalf of the mother and children with an initial expiration date of 7/26/23. The OP was extended through Family Court as a condition of the Article 10 Neglect proceeding. The father was granted supervised visitation with the subject child and sibling.	

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