# NYS Office of Children and Family Services - Child Fatality Report

**Report Identification Number: NY-16-033** **Prepared by: New York City Regional Office**

**Issue Date: 8/11/2016**

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

## Abbreviations

| | | |
|---|---|---|
| **Relationships** | | |
| BM-Biological Mother | SM-Subject Mother | SC-Subject Child |
| BF-Biological Father | SF-Subject Father | OC-Other Child |
| MGM-Maternal Grand Mother | MGF-Maternal Grand Father | FF-Foster Father |
| PGM-Paternal Grand Mother | PGF-Paternal Grand Father | DCP-Day Care Provider |
| MGGM-Maternal Great Grand Mother | MGGF-Maternal Great Grand Father | PGGF-Paternal Great Grand Father |
| PGGM-Paternal Great Grand Mother | MA/MU-Maternal Aunt/Maternal Uncle | PA/PU-Paternal Aunt/Paternal Uncle |
| **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 |
| CPR-Cardio-pulmonary Resuscitation | | |
| **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-Others | |
| **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 | | |

## Case Information

**Report Type:** Child Deceased
**Age:** 16 day(s)
**Jurisdiction:** Kings
**Gender:** Male
**Date of Death:** 02/05/2016
**Initial Date OCFS Notified:** 02/22/2016

## Presenting Information

According to information provided in the completed Form OCFS 7065, the 16-day-old infant was born at 24 weeks gestation and weighed 1.8 pounds. Immediately after his birth he was transferred to the Neo-natal Intensive Care Unit (NICU) and he remained there until he died on 2/5/16. The infant's cause of death was listed as complications related to being born prematurely and other illnesses.

## Executive Summary

This medically fragile newborn infant died on 2/5/16. The ACS case record listed the cause of death as complications related to being born prematurely and the manner as natural. According to a document from the ME dated 5/25/16, the infant's case was referred to the ME for cremation approval only. There was no autopsy performed and there was no autopsy report.

At the time of the infant's birth, ACS was in the process of investigating the 12/18/15 SCR report. The ACS findings showed the infant was born in January 2016 at 24 weeks gestation. Following his birth, he remained in the Jacobi Medical Center NICU where he received care until he was pronounced dead. ACS appropriately monitored the level of care the infant received in the hospital. The infant had three surviving half siblings: the 7-year-old was in the mother's care and 5-year-old and two-year-old had been visiting the MGM out of New York State. ACS found the family had a history of domestic violence incidents and the mother had obtained orders of protection (OOP) against two fathers of the half siblings. The mother informed ACS staff that there was an OOP in place until 2018.

ACS submitted to NYCRO the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive cases. The information regarding the infant's death was reported to OCFS under Chapter 485 of the Laws of 2006. ACS included the information in the open child protective investigation case for further exploration.

ACS learned that the mother visited the hospital at the time the infant was pronounced dead on 2/5/16. The hospital staff had engaged the mother to assess the family's medical needs and to determine whether the 7-year-old half sibling needed respite care. The hospital staff said the mother declined the offer for respite service on 2/5/16. The ACS staff attempted to visit the case address on 2/5/16; however, the effort was unsuccessful. Subsequently, the ACS staff visited the home on 2/7/16 and observed the mother appeared calm and stable. The mother expressed her sadness and the staff offered sympathy and condolence to the mother. The ACS staff provided referral for cremating services. The 7-year-old half sibling was in the home and she did not have observable marks or bruises. During the home visit, the staff reviewed the hospital discharge documents for the mother and half sibling.

The ACS staff visited the 7-year-old half sibling's school and interviewed staff who said the mother did not have a plan to address the half sibling's educational needs. This half sibling was absent 55 days and late 41 days during the 2014-2015 school year. Between September 2015 and February 2016, the half sibling was absent 46 times. The mother planned to take the half sibling out of New York State from 2/16/16 through 3/5/16; thereby increasing the number of school absences.

ACS opened the Family Services Stage of the case on 2/16/16 to monitor parental supervision of the three half siblings, follow up with results of health consultation and offer PPRS. ACS verified that the 5-year-old and 2-year-old half siblings temporarily resided with the MGM out of New York State, and the mother took the 7-year-old half sibling to visit the MGM and the two other half siblings. ACS received information from LE who said an officer visited the MGM's home and observed the three half siblings on 3/1/16. The documentation did not specify the date the three half siblings and mother returned to reside at the case address.

According to the Family Services Progress Notes, ACS staff observed the three half siblings at the ACS office and case address on 3/11/16 and 3/22/16, respectively. The three half siblings did not have marks/bruises and they appeared to have received adequate care. ACS closed the services case on 4/1/16 after the mother declined the agency's offer for PPRS.

## 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

**Explain:**
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:**
N/A

### Required Actions Related to the Fatality

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

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 02/05/2016 **Time of Death:** 02:00 PM

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

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

**Did child have supervision at time of incident leading to death?** Yes
**Is the caretaker listed in the Household Composition?** No
**At time of incident supervisor was:** Not impaired.

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

**Household Composition at time of Fatality**

| Household | Relationship | Role | Gender | Age |
|---|---|---|---|---|
| Deceased Child's Household | Deceased Child | No Role | Male | 16 Day(s) |
| Deceased Child's Household | Mother | No Role | Female | 29 Year(s) |
| Deceased Child's Household | Sibling | No Role | Female | 7 Year(s) |
| Deceased Child's Household | Sibling | No Role | Female | 2 Year(s) |
| Deceased Child's Household | Sibling | No Role | Female | 5 Year(s) |
| Other Household 1 | Mother's Partner | No Role | Male | 34 Year(s) |

**LDSS Response**

Following the infant's death ACS attempted to visit the home on 2/5/16. According to the ACS case record, the effort was unsuccessful. ACS eventually visited the case address on 2/7/16. The staff discussed burial and bereavement services, history of domestic violence and supervision of the 7-year-old half sibling. The 7-year-old half sibling had a diagnosed medical condition, she displayed aggressive behavior, and the mother had not been addressing the educational needs. The mother had previously discussed residential treatment care for the 7-year-old half sibling.

The Child Advocacy Center (CAC) forensic team attempted to interview the 7-year-old half sibling in February 2016. The CAC interview was cancelled because the forensic team sent the half sibling to the Emergency Room for evaluation. This half sibling was later discharged to the mother’s care. The CAC rescheduled the forensic interview to 4/8/16.

As a result of an ACS medical consultation, it was recommended that the agency follow-up with the primary care physician for missed appointments, medical concerns and safety issues. The consultant noted the importance of ensuring the 7-year-old half sibling and the mother receive specialized medical examinations. It was further recommended that the mother obtain information and training to prepare her for taking care of the family's medical needs. ACS staff was advised to explore the mother's trauma history and assess for trauma exposure and stress reaction.

ACS discussed PPRS referral with the mother on 2/12/16. The mother did not accept the offer for services. According to the ACS case record, the mother took the 7-year-old half sibling to visit the MGM out of New York on 2/16/16. The two younger half siblings had been in the temporary care of the MGM's care since January 2016. ACS contacted an assigned police officer in the state where the MGM resided and learned that the assigned officer had visited the MGM's home on 3/1/16 and observed the three surviving half siblings. The ACS case record did not include additional information regarding the officer's observations.

The mother and the three half siblings returned to New York in early March 2016. The mother attended a family meeting at the ACS office on 3/11/16. The meeting identified the following risk concerns: the history of domestic violence concerning two of the children's fathers, trauma of the mother and children and academic failure for the 7-year-old half sibling. The mother said the fathers were not in contact with the half siblings. The mother discussed plans to transfer the 7-year-old half sibling to a different school. She said the current school had not been providing the half sibling's service needs. ACS staff observed the three surviving half siblings and noted they exhibited appropriate interactions with other children who were at the ACS office on 3/11/16. ACS noted that the family would continue to receive therapeutic counseling two times a month for the 7-year-old half sibling and monthly for the mother. The mother had an active legal case custody case on behalf of the 5-year-old and 7-year-old half siblings against their father.

During a 3/18/16 home visit, the Specialist observed the documentation for the 7-year-old half sibling's 3/18/16 medical specialist's appointment and the schedule for follow-up appointments. ACS conducted a follow-up home visit on 3/22/16. During the home visit, the staff learned that the 7-year-old half sibling had been receiving school counseling. The home conditions were satisfactory and the surviving children seemed fine. ACS staff interviewed the family's therapist on 4/1/16. The therapist said the 7-year-old half sibling continued to receive biweekly counseling and the mother was compliant with communication and scheduling. ACS closed the FSS on 4/1/16.

## 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 reviewed by an OCFS approved Child Fatality Review Team?**No
**Comments:** There is no OCFS approved Child Fatality Review Team in NYC.

## 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?** | ☐ | ☒ | ☐ | ☐ |
| **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:**

The ACS case record did not reflect whether the agency attempted to contact the younger half siblings' physician. However, ACS obtained medical records for the older half sibling.

## 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 safety 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** | ☒ | ☐ | ☐ | ☐ |

## 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 siblings/other children in the household removed as a result of this fatality report/investigation?** | ☐ | ☒ | ☐ | ☐ |
| **Explain as necessary:**<br>N/A | | | | |

## 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 | Needed but not Offered | Needed but Unavaliable | 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:**<br>The mother refused the ACS offer for PPRS. | | | | | | | |

**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 monitoring and support services to the surviving children.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
The ACS staff provided casework counseling.

## History Prior to the Fatality

### Child Information

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

## Infants Under One Year Old

**During pregnancy, mother:**

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

**Infant was born:**

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

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 12/18/2015 | 10117 - Sibling, Female, 6 Years | 10118 - Other - Parent Substitute, Male, 34 Years | Internal Injuries | Unfounded | Yes |
| | 10112 - Sibling, Female, 2 Years | 10103 - Mother, Female, 29 Years | Inadequate Guardianship | Unfounded | |
| | 10112 - Sibling, Female, 2 Years | 10118 - Other - Parent Substitute, Male, 34 Years | Inadequate Guardianship | Indicated | |
| | 10115 - Sibling, Female, 4 Years | 10118 - Other - Parent Substitute, Male, 34 Years | Inadequate Guardianship | Indicated | |
| | 10112 - Sibling, Female, 2 Years | 10103 - Mother, Female, 29 Years | Lack of Supervision | Unfounded | |
| | 10115 - Sibling, Female, 4 Years | 10103 - Mother, Female, 29 Years | Inadequate Guardianship | Unfounded | |
| | 10115 - Sibling, Female, 4 Years | 10103 - Mother, Female, 29 Years | Lack of Supervision | Unfounded | |
| | 10117 - Sibling, Female, 6 Years | 10103 - Mother, Female, 29 Years | Lack of Medical Care | Unfounded | |
| | 10117 - Sibling, Female, 6 Years | 10118 - Other - Parent Substitute, Male, 34 Years | Sexual Abuse | Unfounded | |
| | 10117 - Sibling, Female, 6 Years | 10103 - Mother, Female, 29 Years | Educational Neglect | Indicated | |
| | 10117 - Sibling, Female, 6 Years | 10118 - Other - Parent Substitute, Male, 34 Years | Inadequate Guardianship | Indicated | |
| | 10117 - Sibling, Female, 6 Years | 10103 - Mother, Female, 29 Years | Inadequate Guardianship | Indicated | |

| | | | |
|---|---|---|---|
| 10117 - Sibling, Female, 6 Years | 10103 - Mother, Female, 29 Years | Lack of Supervision | Indicated |

**Report Summary:**
The 12/18/15 report alleged there was a history of the parent substitute being physically abusive to the mother in the presence of the half siblings who were then six years, four years and two years old. The parent substitute pushed the mother against the wall and choked her until she lost consciousness, he threatened to kill her and pulled out a gun in front of the children. The mother had an unknown role.

The SCR registered six subsequent reports dated 12/22/15 (three reports), 1/5/16, 1/12/16, 1/31/16. A 12/22/15 report alleged the mother's male paramour raped the half sibling who was then six years old. The report alleged that this half sibling had 34 school absences.

**Determination:** Indicated | **Date of Determination:** 02/16/2016

**Basis for Determination:**
ACS substantiated the allegations of EdN, IG and LS of the 6-year-old half sibling by the mother on the basis that the mother kept the child from attending school and the child had excessive school absences. The mother admittedly left the child alone without supervision in the hospital family room although the mother was aware the child had a history of running. ACS substantiated the allegation of IG of the three children by the parent substitute on the basis that he engaged in acts of domestic violence while the children were in the parent's care. ACS unsubstantiated the allegations of II, LMC and SA stemming from the 12/18/15 and six subsequent SCR reports.

**OCFS Review Results:**
ACS was investigating the 12/18/15 report when SCR registered six subsequent reports. The subsequent reports included the allegations of EdN, IG, LMC, II, SA, and LS. ACS consolidated the investigations of these reports. ACS staff observed the three half siblings and interviewed the mother who said she sought LE intervention and obtained orders of protection against two of the children's fathers. The mother did not adequately supervise the 6-year-old half sibling. This half sibling had excessive unexcused school absences and had failed classes. In January 2016, the mother gave birth to the infant who remained in the hospital.

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

**Issue:**
Failure to provide notice of report
**Summary:**
ACS did not provide the notice of the report 12/18/15 report to the parents who were the subjects.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

**Issue:**
Failure to Provide Notice of Indication
**Summary:**
ACS did not provide the Notice of Indication for the 12/18/15 report to the parents who were listed as the subjects.
**Legal Reference:**
18 NYCRR 432.2(f)(3)(xi)
**Action:**
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to

address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

**Issue:**
Timely/Adequate Case Recording/Progress Notes
**Summary:**
ACS did not enter several Investigation Progress Notes within the 30-day timeframe.
**Legal Reference:**
18 NYCRR 428.5(a) and (c)
**Action:**
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

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

The mother was known to the SCR and ACS as a subject in seven reports dated 7/31/11, 10/12/11, 10/18/11, 10/22/11, 2/4/12 (two reports) and 2/8/12. The subject children were the deceased infant's two half siblings (now 7 years old and 5 years old) and their father's male child from a previous relationship.

The allegation of the 7/31/11 report was IG of the three children by their parents. The report was unfounded and legally sealed.

The 10/12/11 report included the allegations of IG of the two half siblings by their parents and IG and PD/AM of the male child by the half sibling's father. The 10/18/11 and 10/22/11 reports were merged into the open 10/21/11 investigation. ACS unsubstantiated the allegation of IG pertaining to the mother. ACS substantiated the allegations concerning the half sibling's father.

The 2/4/12 report included the allegations of IF/CS, IG and PD/AM of the two half siblings by the mother, IG of the male child by the mother and the half siblings' father, and LMC of the male child by the half siblings' father. The 2/8/12 report was merged into the 2/4/12 investigation. ACS unsubstantiated the allegations pertaining to the mother. ACS substantiated the allegations of IG of the two half siblings and the male child and LMC of the male child by the half sibling's father. The family received services to address domestic violence incidents and medical need.

### Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

## Services Open at the Time of the Fatality

### Required Action(s)

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

## Preventive Services History

As a result of an Article Ten Neglect petition filed on 10/27/11, the Family Court ordered ACS supervision for the mother's family. The household composition included the mother, the deceased infant's two half siblings, and the two half siblings' father and his male child from a previous relationship. After a domestic violence incident, the father of the half siblings left the case address without planning for the children. There was an order of protection in place.

According to the Family Services Progress Notes, the family received domestic violence and family and individual counseling. The half sibling's father received housing, batterer's program, random drug/alcohol tests and case management services. This father completed 26-week domestic violence program and parenting skills classes on 12/18/13. The Child Care Review Service records showed as of 2/18/14, the two half siblings were discharged from their father's service case. The reason was listed as an administrative action. The two half siblings remained in the mother's care.

## Casework Contacts

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Were face-to-face contacts with the child in the child's placement location made with the required frequency?** | ☒ | ☐ | ☐ | ☐ |

## Required Action(s)

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

## Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

## 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

| **Have any Orders of Protection been issued?** Yes | |
|---|---|
| **From:** Unknown | **To:** Unknown |
| **Explain:** | |

The mother had a history of domestic violence in her relationships with the infant's father and the 5-year-old and 7-year-old half siblings' father. The mother no longer resided with any of the children's fathers. She ended her relationship with the infant's father after a 10/23/15 domestic violence incident. The mother contacted law enforcement and the father was arrested. As a result of the incident, the mother and the three surviving half siblings resided in a domestic violence shelter in November 2015. Subsequently, the mother and half siblings temporarily resided with the MGM out of New York State. She returned to reside at the case address on 12/12/15 because of a custody arrangement with the father of the 5-year-old and 7-year-old half siblings.

The mother had a visitation/custody case with the father of the 5-year-old and 7-year-old half siblings. The mother said there was an order of protection in place until 2018. The ACS case record did not include updated information about the specific dates of the orders of protection and the legal case.

## Additional Local District Comments

N/A

## 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