Child Fatality Report

Report Identification Number: NY-17-108

Prepared by: New York City Regional Office

Issue Date: Apr 03, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 0 day(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 10/08/2017
Initial Date OCFS Notified: 10/11/2017

Presenting Information

The 10/11/17 SCR report alleged that the SM gave birth to the SC in the train station on 10/8/17. EMS was contacted and they worked on the SC. EMS then transported the SM and SC to the hospital where the SM was admitted and the SC was dead upon arrival. The SM checked herself out of the hospital on 10/9/17 against medical advice. The SM believed the SC was in the neo-natal intensive care unit with a medical condition. The SM also felt she was pregnant with three children, but only gave birth to one. The SM had been diagnosed with depression and was also suffering from other unknown mental illness. The SM was not under a physician's care. The SF had an unknown role.

Executive Summary

The female infant (SC) died on 10/8/17, and on 10/11/17 the SCR registered a report with allegations of DOA/Fatality and IG of the SC by the SM. As of 4/3/18, NYCRO has not received the ME's final report.

The SC was taken to the hospital on 10/8/17 and died upon arrival. At the time of the SC’s death, ACS had an open services case to address concerns of LMC, and IG of the SS, and to provide foster care services to the family.

ACS obtained information from the Investigative Consultant (IC), LE, EMS, medical professionals, shelter staff and family members. ACS met with medical staff and obtained accounts of the incident. The ME's preliminary findings revealed there were no suspicions regarding the SC's death. LE found there was no criminality. The EMS assigned staff stated that EMS responded and found the SM on the subway platform. EMS observed a midwife cutting the umbilical cord and performing CPR on the SC. ACS learned that the shelter staff asked the SM for hospital discharge papers and photos of the SC; however, the SM could not provide the discharge papers and photos to the shelter staff; therefore, the staff deemed the SM’s actions as suspicious.

ACS contacted the attending physician and learned that the SM was transported by EMS to the hospital. The medical records showed the SC was deceased upon arrival and the SM refused to provide a urine toxicology. The hospital medical staff recommended that the SM remain in the hospital for two additional days after the SC’s birth for medical observation; however, the SM refused medical treatment.

The ACS Specialist contacted the SM’s prenatal clinic and learned that the SM had a medical condition during her pregnancy. The SM was referred to the local hospital for follow-up because she required hospitalization; however, the SM left the prenatal clinic and refused treatment.

ACS contacted the Children’s Aid Society and obtained the status of the SSs. ACS learned that the foster care agency had begun the Termination or Parental Rights in 2016. ACS assessed the SSs; the children were neat and without visible marks or bruises.

On 12/20/17, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the SM on the basis that the SM gave birth to the SC who "was pronounced dead during the delivery." ACS did not provide justification for the decision to substantiate the allegations, thereby failing to appropriately apply the standards of abuse/maltreatment to the case circumstances. The ACS investigation conclusion narrative did not include information to determine whether the SM's actions or inactions contributed to the SC's death.

As of 4/3/18, the SSs remained in foster care placement.

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?** No

Explain:
ACS did not appropriately apply the standards of abuse/maltreatment to the case circumstances

Was the decision to close the case appropriate? N/A

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:
The 10/11/17 investigation was indicated on 12/20/17. The service case remained open with foster care services.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	For the 10/11/17, report, ACS did not complete the 24-hour assessment within the required timeframe. The 24 hour assessment was completed on 10/13/2017.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a PIP 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:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 10/11/17 report, ACS did not complete the 24-hour report within the required timeframe. The 24 hour fatality report was completed on 10/13/17.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must submit a PIP 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:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	ACS substantiated the allegations of DOA/Fatality and IG of the SC by the SM; however, ACS did not appropriately apply the legal standard of abuse/maltreatment to the case circumstances.
Legal Reference:	SSL 412(1) and 412(2)
Action:	ACS must submit a PIP 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/08/2017 **Time of Death:** Unknown

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
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? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were impaired.

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

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	0 Day(s)
Deceased Child's Household	Father	No Role	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Other Household 1	Sibling	No Role	Female	2 Year(s)
Other Household 1	Sibling	No Role	Male	10 Month(s)
Other Household 1	Sibling	No Role	Male	6 Year(s)
Other Household 1	Sibling	No Role	Male	4 Year(s)

LDSS Response

On 10/12/17, ACS contacted the shelter staff and learned that the SM arrived at the shelter on 5/27/17. The staff described the SM as non-problematic.

On 10/12/17, contacted the Women's Clinic and verified the SM attended three prenatal visits throughout her pregnancy. The medical personnel said the SM was inconsistent with pre-natal care.

ACS reviewed the family's child welfare history as the four SSs had remained in kinship foster care with the Children's Aid Society. ACS noted that Children's Aid Society filed a Termination of Parental Rights in Kings County Family Court in December 2016. On 10/12/17, ACS staff met with the mental health, medical and investigative consultants and discussed the case history and reported concerns. The consultants recommended review of the EMS report, hospital discharge papers and LE findings.

On 10/13/17, ACS contacted the shelter staff and confirmed that the Department of Homeless Services was notified of the SC's death. On 11/9/17, ACS learned from shelter staff that the SM was discharged from the shelter. The SM's whereabouts were unknown. ACS attempted to contact the MGM, SM and BF via phone; however, attempts were unsuccessful.

On 11/13/17, ACS convened the 30-day Heightened Oversight conference (HOP) and met with the consultants to review the fatality. The consultants recommended that ACS refer the SM to mental health services. The investigative consultant recommended that ACS contact LE for their findings.

On 11/22/17, ACS had a phone conference with the CAC to discuss the fatality case. An overview of the case was provided and no additional information was obtained.

On 12/1/17, ACS contacted the ME and sent a written request to obtain the autopsy report on the SC.

On 12/20/17, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the SM on the basis that the SM gave birth to the SC who "was pronounced dead during the delivery." ACS did not provide justification for the decision to substantiate the allegations, thereby failing to appropriately apply the standards of abuse/maltreatment to the case circumstances. The ACS investigation conclusion narrative did not include information to determine whether the SM's actions or inactions contributed to the SC's death.

As of 4/3/18, the SSs remained in foster care placement.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
044352 - Deceased Child, Female, 0 Days	044564 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
044352 - Deceased Child, Female, 0 Days	044564 - Mother, Female, 31 Year(s)	DOA / Fatality	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐

Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The ACS was unable to interview the SM whose whereabouts were unknown.

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?	☒	☐	☐	☐

Explain:
There 24 hour and 30 day assessments were not completed in a timely manner.

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 RAP was not consistent with investigative information. The documented information did not reflect the four SSs were in the care of substitute caregivers prior to the 10/11/17 report.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The SSs were removed from the SM and BF for reasons unrelated to the fatality and they were not in the SM and BF's care at the time of the fatality report.

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Supervised Visitation							
Additional information, if necessary: ACS provided the family with foster care services and supervised visitation.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
The SSs were not in the SM's household during the fatality. The SSs were placed in foster care prior to the fatality and did not have knowledge that the SM was pregnant with the SC.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The SM's whereabouts remained unknown.

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? 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
☐ 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)
05/17/2017	Sibling, Male, 5 Years	Mother, Female, 31 Years	Lacerations / Bruises / Welts	Indicated	Yes
	Sibling, Male, 5 Years	Mother, Female, 31 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 5/17/17 SCR report alleged that during an unsupervised visitation on 5/17/17, the SM struck the SS, who was then five years old, in the arms leaving bruising. All the other SS were in foster care due to the SM's maltreatment of them in the past. The other SS had unknown roles.

Determination: Indicated | **Date of Determination:** 07/14/2017

Basis for Determination:
ACS substantiated the allegations of IG and L/B/W of the SS by the SM. ACS noted there was credible evidence to support the allegations. The SS was observed with marks or bruises. The SM had an unsupervised visit with the SS on 5/17/17. ACS learned that the foster parent observed a bruise on the SS's arm. The agency took pictures of the SS's bodies prior to the SM and SS's visit. The SM reported that the bruise was from a vaccination that the SS received. ACS found that the SM inflicted bruises on the SS.

OCFS Review Results:
OCFS NYCRO's review revealed that ACS made thorough assessments regarding the family's needs. ACS did not enter progress notes contemporaneously. ACS did not make relevant collateral contacts to obtain information from the schools, foster care agency and Dr.

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

Issue:
Adequacy of Progress Notes

Summary:
ACS progress notes were not documented contemporaneously in the 5/17/17 report. The progress notes were not documented within 30 days of the event dates. Several progress notes had an event date of 6/8/17 and entry date of 7/12/17.

Legal Reference:
18 NYCRR 428.5

Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/21/2016	Sibling, Male, 1 Hours	Mother, Female, 30 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Male, 1 Hours	Father, Male, 32 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 12/21/16 SCR report alleged that the SM gave birth to a male child in December 2016 and had three other children in foster care. There were concerns of domestic violence.

Determination: Indicated | **Date of Determination:** 02/17/2017

Basis for Determination:
ACS substantiated the allegation of IG of the SS by the SM and BF. ACS documented that there was credible evidence to support the allegation. The SM delivered the SS at home and called EMS. The BF was referred to parenting classes and

had failed to complete class and showed no interest. The SM completed parenting classes, mental health assessment and CPR class and went to medical appointments for the child. The parents had three older children who remained in foster care. The newborn SS was remanded to the care and custody of LDSS.

OCFS Review Results:
OCFS NYCRO review revealed that ACS entered timely progress notes. ACS made thorough assessments regarding the family's needs. ACS obtained relevant information from the local hospital, MGM, foster care agency, Family Court and community based service provider. ACS completed a RAP; however, the documentation did not reflect that the family had recent history of housing with serious health or safety hazards.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
ACS completed a RAP; however, the documentation did not reflect that the subject family had recent history of housing with serious health or safety hazards, unstable or no housing in the 12/21/16 investigation. ACS did not enter progress notes contemporaneously in the 12/21/16 investigation.

Legal Reference:
18 NYCRR 432.2(d)

Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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 progress notes contemporaneously in the 12/21/16 investigation.

Legal Reference:
18 NYCRR 428.5

Action:
ACS must submit a PIP 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/13/2015	Sibling, Male, 4 Years	Father, Male, 31 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Female, 1 Days	Father, Male, 31 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 1 Days	Mother, Female, 29 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 2 Years	Father, Male, 31 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 1 Days	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Indicated	

Sibling, Female, 1 Days	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Female, 1 Days	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Indicated

Report Summary:
The 7/13/15 SCR report alleged that in July 2015 the SM gave birth to a female child. The SM tested positive for marijuana. The results of the infant female's tests were unknown at the time.

Determination: Indicated | **Date of Determination:** 09/11/2015

Basis for Determination:
ACS substantiated the allegations of IF/CS, IG and PD/AM stemming from the 7/13/15 report. ACS learned that the SM tested positive for marijuana while giving birth to the SS and the SM admitted to smoking marijuana. The SC was diagnosed with a medical condition as the BF and SM only fed the SC pureed fruits, vegetables and limited breast milk. As a result of inadequate feeding, the SC was admitted into the hospital for treatment of her pre-existing medical condition, dehydration, low weight and low protein. The allegation of IG by the SM and BF was substantiated as they had failed to provide nutrients and failed to seek medical care when directed by ACS.

OCFS Review Results:
OCFS NYCRO review revealed that ACS entered timely progress notes. ACS made thorough assessments regarding the family's needs. ACS made relevant collateral contact with the local hospital, MGM, foster care agency and SC's medical Dr., and Family Court Legal Services. ACS inappropriately completed the RAP as the agency did not include information about the family's unstable housing condition.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
ACS completed a RAP; however, the documentation did not reflect that the family had recent history of housing with serious health or safety hazards, unstable or no housing in the 7/13/15 investigation.

Legal Reference:
18 NYCRR 432.2(d)

Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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 SM and the BF were known to the SCR and ACS as subjects in a report dated 11/25/13. The allegations of the report were IG, LMC, PD/AM of the SS who resided in the home. On 1/28/14, ACS substantiated the allegations of the 11/25/13 report. The report was indicated and ACS closed the investigation.

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 Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 08/27/2015

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

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐

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 9/22/17 reassessment FASP was three days overdue.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Required Action(s)

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

Issue:	Adequacy of Progress Notes
Summary:	The Children's Aid Society agency did not enter progress notes contemporaneously as some notes were entered 30 days after the event date.
Legal Reference:	18 NYCRR 428.5
Action:	The Children's Aid Society agency must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. Children's Aid Society 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:	Timeliness of completion of FASP
Summary:	The 9/22/17 reassessment FASP was three days overdue. The FASP was due on 9/22/17 and approved on 9/25/17.
Legal Reference:	18 NYCRR428.3(f)
Action:	The Children's Aid Society agency must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. CAS 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.

Foster Care Placement History

ACS filed Article Ten Neglect petitions on behalf of the four SS against the SM and BF in the Kings County Family Court on 8/26/2015 and 12/23/2016. The four SS were remanded to the care and custody of LDSS.

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:**
08/27/2015	There was not a fact finding	Foster Care Placement to Continue
Respondent:	044564 Mother Female 31 Year(s)	
Comments:	The court ordered the SS to remain in foster care at the conclusion of the 1028/permanency hearing/disposition in May 2017.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
08/27/2015	There was not a fact finding	Foster Care Placement to Continue
Respondent:	044565 Father Male 32 Year(s)	
Comments:	The court ordered the SS to remain in foster care at the conclusion of the 1028/permanency hearing/disposition in May 2017.	

Have any Orders of Protection been issued? Yes	
From: 05/08/2017	**To:** 05/08/2018
Explain: The Kings County Family Court issued an order of protection on 5/18/18 on behalf of the SS against the SF.	

Additional Local District Comments

There are no additional local district comments.

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