Child Fatality Report

Report Identification Number: NY-19-066

Prepared by: New York City Regional Office

Issue Date: Nov 15, 2019

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: 06/05/2019
Initial Date OCFS Notified: 06/11/2019

Presenting Information

OCFS was notified of the child's death via telephone, on 6/11/19 by the preventive services (PPRS) agency that provided services to the case family. On 6/12/19, the PPRS provided formal notification to OCFS.

Per the notification, on 6/11/19 the BF called the PPRS Case Planner (CP) and informed the CP the BM had given birth; and the newborn died in the hospital. The BF asked whether there was money for cremation. This is all that was known at the time; a home visit (HV) was planned for 6/12/19.

Executive Summary

This fatality report concerns the death of a newborn female child (SC) that occurred on 6/5/19. The SC's BF reported her birth and death to the preventive services provider on 6/11/19.

There was no report generated to the SCR regarding the SC's death.

The NYC Medical Examiner's office issued a response letter to OCFS on 8/9/19, that stated the SC's death was not under their jurisdiction.

At the time of the SC's death, her family had an open preventive services (PPRS) case.

Per case documentation, on 7/27/18, a maltreatment report was generated to the SCR that alleged IG and PD/AM by the BM against the SS. During the investigation, CPS referred the family for Family Treatment Rehabilitation (FT/R) preventive services on 8/2/18. CPS determined the allegations of the report were UNF on 9/25/18.

The family received service referrals for Early Intervention (EI), Homemaking, and Visiting Nurse Services (VNS) for the SS. In addition, substance abuse treatment and parenting training for parents with special needs children referrals were provided to the BM. The BF completed a similar parenting training at the time of the PPRS referral. Given case circumstances, CPS assessed the family no longer required FT/R services and on 1/22/19, re-referred the family to another PPRS provider for less intensive, GP services. A Joint Home Visit (JHV) occurred on 2/7/19 with PPRS Case Planners (CP's) and PPRS was discussed with the family. On 3/18/19, a subsequent JHV occurred with the CP, CPS and both parents; the purpose and benefits of PPRS were discussed with the parents.

Prior to the SC's death, the BM, BF, and 10-month-old male SS resided in a NYC Department of Homeless Services (DHS) one-bedroom, family shelter apartment. Following notification of the SC's death, the CP and supervisor successfully conducted a shelter home visit (HV) on 6/17/19, with the parents and SS. During this visit, a well-being assessment occurred of the SS, condolences and offer of bereavement services were offered to the parents which they declined.

Due to the parents requesting closure of their PPRS case, the CP requested a Service Termination Conference (STC) on 8/22/19; it was scheduled and held on 9/13/19. An ACS facilitator, the PPRS CP and supervisor, and the BF participated in the STC; there were no child welfare concerns assessed for the SS. Therefore, the PPRS case was closed on 10/1/19.

OCFS gathered information for this report from CONNECTIONS, ACS CPS records, PPRS records, interviews with the PPRS program director and CP, and the NYC Office of Chief Medical Examiner.

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:
There were no allegations relating to the SC's death reported to the SCR; therefore, there was no LDSS/CPS investigation or involvement. The CP assessed the safety and wellbeing of the SS, attempted to gather significant information during HV's and telephone contacts with the family. However, the family declined further participation in services, and the PPRS case was closed on 10/1/19.

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:
On 5/22/19, the family made an initial request for closure of the PPRS case and refused all further contact and services from the PPRS agency. Post the untimely demise of the SC, the CP assessed and determined there were no safety concerns. The CP attempted to engage the family who refused to provide the agency with additional information, and continued to request closure of the PPRS case.

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: 06/05/2019 **Time of Death:** Unknown

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

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

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: In utero prior to death

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	0 Day(s)
Deceased Child's Household	Father	No Role	Male	35 Year(s)
Deceased Child's Household	Mother	No Role	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Month(s)

LDSS Response

Following the BF's 6/11/19 call to the agency concerning the SC's death, the CP and supervisor conducted a HV on 6/17/19. During the HV, the BM, BF, and SS were observed. The SS appeared free of any visible marks and bruises; his crib was free of objects. The parents were familiar with Safe Sleep for Babies recommendations; a safe sleep poster was affixed to the wall. The CP discussed the Elevated Risk Conference (ERC) and STC due to parental case closure requests, and parental refusal to sign consents for confirmation of the SS's medical care; they refused participation. The CP offered the parents burial assistance and bereavement counseling; only burial assistance was accepted. The BF shared the family was approved for supportive housing; the CP would follow up with the shelter Case Manager (CM). Initially, the parents declined services; then agreed to continue with PPRS and participate in grief counseling. The BM signed the medical consents; therefore, the ERC was cancelled.

On 6/18/19, the PPRS supervisor phoned the BF informing that on 6/17/19, the agency paid the funeral home for the SC's cremation. The BF discussed the BM's prenatal care, sharing that the SC was born at 22 weeks gestation and died shortly thereafter at a Bronx Hospital; the funeral home had collected the SC's remains; and the BF was interested in receiving grief counseling. The supervisor stated the program's mental health consultant could schedule intake.

On 6/26/19, the CP conducted a HV with the BF, BM, and SS. The CP observed objects in the SS's crib and discussed Safe Sleep with the parents. The BM informed they were collecting the SC's ashes on Friday. The CP then asked parents to call the consultant to schedule grief counseling and the BF told the CP to do that on the CP's own time; they would not call.

At a 7/12/19 HV with the BF, BM, and SS, the CP observed blankets and toys in the SS's crib and again discussed Safe Sleep. BM said the items were there because they were cleaning. The BF told the CP they were receiving grief counseling from the shelter CM. On 7/13/19, the CP phoned the CM who stated the parents resisted sharing information, was unaware if the SS received services, and was not providing grief counseling to them.

On 7/12/19, the CP phoned the SS's pediatrician and left voicemail requesting treatment updates. Also contacted was the SS's neurologist whose staff confirmed a 7/3/19 appointment was kept. On 7/16/19, the neurologist's staff informed the CP the SS's 7/9/19 appointment was kept; that future appointments would be yearly. The hospital Family Services Complex Care nurse returned the CP's call on 7/17/19 confirming the parents kept the SS's May 2019 appointment. On 7/18/19, the CP spoke with the hospital social worker who confirmed the parents were keeping the SS's appointments, and that the SS should be getting EI. The worker was unsure if he was receiving it as 'the city', not hospital offered that service.

On 7/18/19, the CP left voicemail for the BF reminding of an Family Team Conference (FTC) on 7/26/19. The BM returned the CP's call stating she did not want PPRS, and felt forced to accept services; the CP explained the STC process. On same date, the BF phoned the CP stating PPRS was giving stress to the family and wanted it terminated; the CP explained the case closure process.

On 7/31/19, the PPRS supervisor conducted a HV with the BM, BF, and SS who was assessed. STC scheduling was discussed. The BF said he was unsure he wanted PPRS to end; he felt they had to keep the case open because the agency paid for the SC's funeral. BF was told they should not feel forced, that service was provided by the agency.

An STC occurred on 9/13/19; the PPRS case was closed 10/1/19.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Not applicable. There is no OCFS approved Child Fatality Review Team (CFRT) 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?	☒	☐	☐	☐
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:
There was no SCR report that alleged DOA/Fatality for the SC. Therefore, there was no LDSS/CPS investigation. According to the ME's office, the death of the SC did not fall under the jurisdiction of the Office of Chief Medical Examiner.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☒	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Explain:
On 6/11/19, the BF notified the agency nearly a week after the SC's demise in the hospital; as he requested food vouchers and burial assistance for the SC. Upon the notification of the SC's death, the agency immediately attempted to assess the safety and wellbeing of the SS. However, the family refused to provide the agency with information or respond to the CP's contact attempts. On 6/17/19, the CP made a successful HV and a safety assessment of the SS occurred; no concerns were noted.

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:
On 5/22/19, the family requested the closure of the services case and refused to respond to further contacts and services from the agency. On 6/11/19, the BF notified the agency of the SC's premature birth and untimely demise in the hospital. The parents refused to provide the agency with additional information, and consistently requested the PPRS case closed. They would accept, then refuse service referrals when they made themselves available.
For a short period in early 2019, the family received homemaking and VNS services; the SS received EI services in the shelter home.

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?	☐	☒	☐	☐

Explain as necessary:
No SCR report was made regarding the SC's death. There was no LDSS/CPS investigation or involvement.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐

Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
PPRS was provided to the family. The parent requested and received financial assistance for funeral arrangements from the PPRS; then declined to furnish the PPRS with copy of the SC's death certificate. The parents refused services and declined further communication and contact attempts by the PPRS. No child welfare concerns were assessed at a 9/13/19 STC; the PPRS case was closed on 10/1/19.

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:
Throughout the services period, the parents consistently refused to provide medical consents so that the PPRS CP could obtain information necessary to assess the SS who was 10 months old with special needs. Consent was not given until 7/18/19. Also, prior to the SC's death, the family refused to maintain contact and/or accept referred services. For a brief period in 2019, the family received homemaking and VNS services; the SS received EI in-home services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The family refused casework contact attempts and services from the agency at the time of the SC's untimely demise. For a brief period in 2019, the family received homemaking and VNS services; the SS received EI services in the shelter home. Following the SC's death, the parents accepted then later declined, the agency's referral offer for bereavement counseling; they also requested closure of the PPRS case.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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? No

Infants Under One Year Old

During pregnancy, mother:
☒ Had medical complications / infections ☐ Had heavy alcohol use

☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Was not noted in the case record to have any of the issues listed
☐ 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)	Allegation Outcome	Compliance Issue(s)
02/28/2019	Sibling, Male, 7 Months	Mother, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 7 Months	Mother, Female, 23 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Male, 7 Months	Father, Male, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Months	Father, Male, 34 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The 2/28/19 SCR report alleged that the then seven-month-old SS lived with the parents. The SS was born with complex medical issues including a brain bleed. Follow-up appointments with a medical specialist were made. At date of the report, the parents missed four appointments with the medical specialist.

Report Determination: Unfounded | **Date of Determination:** 04/24/2019

Basis for Determination:
ACS found no credible evidence to substantiate the allegations of the report. Throughout the course of the investigation, ACS made several HV's to the family home. On all occasions the SS was observed to be well cared for, free of marks and bruises, well nourished and appropriately groomed. On 3/19/19, the SS was seen by the medical specialist who had no safety concerns regarding the care the parents provided.

OCFS Review Results:
ACS gathered sufficient information to make a determination for all allegations including those on the intake report in the course of the investigation. The determination made by ACS to unsubstantiate the reported allegations was appropriate. The safety decision recorded on the safety assessment at the time of the investigation determination was appropriate and commensurate with case circumstances.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/27/2018	Sibling, Male, 1 Days	Mother, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 1 Days	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
On 7/27/18, the SCR report alleged the BM gave birth to the SS. The BM tested positive for marijuana. Unknown role for the BF at the time.

Report Determination: Unfounded | **Date of Determination:** 09/25/2018

Basis for Determination:
ACS unsubstantiated the allegations of the report due to lack of credible evidence that the BM's positive marijuana test at

time of the SS's birth resulted in the SS's premature birth, or that the SS was in immediate or impending danger of serious harm. The SS tested negative for illicit substances at birth.

OCFS Review Results:
ACS gathered sufficient information to make determination for all allegations including those listed on the intake report in the course of the investigation. The determination made by ACS to unsubstantiate the reported allegations was appropriate. The safety decision recorded at the time of the investigation determination was appropriate and commensurate with case circumstances.

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

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

As an adult, the BM had no CPS history more than 3 years prior to the fatality.

The BF has significant CPS history from 2009 to 2015. The BF was the confirmed subject in 5 CPS investigations involving his 3 children, (the SC's step-siblings now ages 18, 15, & 12), and their BM.

The 4/15/15-7/1/15 Albany County CPS investigation for IG, PD/AM and CD/AU of the 3 children by the BF was Indicated (IND).

The BF was the confirmed subject of 4 ACS CPS investigations from 2009 to 2014:

The 4/3/14-6/2/14 investigation for allegations of EdN, IG, CD/AU of 1 child (now 18-yo) by the BF was IND.
The 12/2/09-1/29/10 investigation for IG and PD/AM of the 3 children by the BF was IND.
The 9/21/09-11/4/09 investigation for PD/AM of the 3 children by the BF was IND.
The 4/2/09-5/27/09 investigation for IG and PD/AM of the 3 children by the BF was IND.

The BF has a history of drug use; marijuana and cocaine specifically, as well as a history of DV; namely verbal abuse against the BM of his 3 children.

Known CPS History Outside of NYS

There was no known CPS history for either parent 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: 02/05/2018

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: 02/05/2018

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 Reassessment FASP due date was 9/1/19, it was approved on 9/9/19.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

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

Provider

	Yes	No	N/A	Unable to Determine

Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
A voluntary service provider initially provided intensive PPRS; the family was assessed and re-referred for general preventive services with another PPRS.

Preventive Services History

CPS' 4/2/09 investigation of IG and PD/AM for the BF's three eldest children by the BF was IND. As a result, a PPRS case was opened on 4/15/09. On 5/6/10, the PPRS case was closed as the three children and their BM relocated to a DV shelter.

Following CPS' INV of a 7/27/18 SCR report, CPS referred the family (BM, BF and SS) for FT/R PPRS on 8/2/18. The family received referrals for EI, Homemaking, and VNS. CPS assessed the family no longer required FT/R services, and re-referred the family for less intensive, GP PPRS services.

On 2/7/19, a JHV was conducted with CPS and the PPRS CP's. Intake with the family occurred on 3/12/19. Successful HV's occurred on 3/18/19 and 5/9/19, attempted HV's were made on 4/10/19 and 4/15/19, and an Office Visit (OV) on 4/17/19. During a phone contact with the CP on 5/22/19, the BF requested the immediate case closure. Subsequently, the parents did not respond to phone or HV contact attempts by the CP.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No