NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-031 **Prepared by: New York City Regional Office**

Issue Date: 10/26/2016

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
FM-Foster Mother	SS-Surviving Sibling	

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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 12 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 04/04/2016
Initial Date OCFS Notified: 04/04/2016

Presenting Information

The 4/4/16 report alleged that on 4/4/16, the 12-year-old child was found unresponsive in his bed. The child had a pre-existing medical condition and developmental disability. There was no explanation for the child's sudden death. As a result his death was considered suspicious. All adults in the household were considered alleged subjects.

The SCR registered a subsequent report on 4/4/16. The report alleged that on 4/4/16, the 12-year-old child was found deceased in his bed. There was no explanation of the child's sudden death which was considered suspicious at the time. The condition of the home was deplorable with garbage on all the floors and the apartment in total disarray; therefore, the 2-year-old child was placed at risk

Executive Summary

The medically fragile 12-year-old male child died on 4/4/16. As of 9/23/16, NYCRO has not yet received the ME report.

The allegations of the 4/4/16 reports were DOA/Fatality and IG of the 12-year-old child by the SM, parental substitute (PS), and adult female half-sibling (AFHS).

ACS investigation revealed that the child had a pre-existing medical condition and developmental disabilities. The 12-year-old child used the bathroom at about 4:00 AM on 4/4/16 and then he stood near the SM's bed. The SM said she observed the child was near her bed and she directed him to return to his bed to sleep. At about 8:00 AM, the SM left the home to purchase food. The SM returned about 10:00 AM and noted the 2-year-old half sibling, 12-year-old, and AFHS were asleep. The PS was in the home to assist with child care duties. The SM left the home to do the laundry, returned at about 11:00 AM and found everyone was still asleep. The AFHS woke and the SM asked the AFHS to check on the children. The SM reported the AFHS entered the room, came out and said the children were fine. The AFHS then left the home and went to the laundry. At about 11:30 AM the 2-year-old half sibling woke. The SM explained that at that time she thought something was wrong with the 12-year-old child and she entered the room and observed he appeared to be asleep on his side facing the wall. She called his name and he did not respond. She touched his shoulder, found his skin was cold and she then tried to turn him. She observed he was gray and had been dead for sometime. She called 911 for assistance and the responders came to the home.

The child had been using prescribed medications for his medical condition. The SM showed ACS a medication which was filled 2/9/16; it seemed very little had been used. The SM showed another medication with four capsules prescribed twice per day for the child. The prescription was filled on 3/4/16 and seemed to have been used as it was half used. The last medication was prescribed on 12/18/15 and the container was full.

On 4/6/16, ACS filed an Article Ten Neglect Petition in Kings County Family Court (KCFC) on behalf of the 2-year-old half sibling naming the SM and PS as the respondents. The Family Court Legal Service (FCLS) did not believe the AFHS was a person legally responsible for the 2-year-old child. The KCFC granted the remand over the mother’s

objections.

The 2-year-old child was placed in kinship foster care with the mother's cousin. On 4/8/16, ACS referred the SM for health services, grief counseling, alcohol screening/drug testing, parenting classes, anger management and DV counseling.

On 7/21/16, the ME (by telephone) informed ACS that the preliminary cause of death was listed as a medical condition. There was no finding that was consistent with abuse and/or neglect. The ME said there were three medications found in the child's system at the time of death. Two of the medications were found to be in therapeutic levels; two medications were administered as prescribed. The other medication was slightly below the therapeutic level, described as "sub-therapeutic" level. The ME could not state that this level would have increased or decreased the child's chances of experiencing the medical symptoms associated with the death. Depending on the time the medication was administered the level would be slightly low, as the level of the medication would increase and/or decrease depending on the time the medication was administered. For example, if the medication was given shortly before death the level would be normal; but if the medication was given hours prior to death, then the level would be low and would again increase upon the medication being administered. The ME could not state whether the sleep position contributed to the child's death.

ACS did not interview the school staff to obtain information about the child's health.

As of 10/4/16, ACS has not yet determined the report.

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?** Unable to Determine
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
NA

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

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:
NA

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: 04/04/2016 **Time of Death:** 01:51 PM

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: 01:44 PM
Did EMS to respond to the scene? Yes
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? Yes - Caregiver 1
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	Alleged Victim	Male	12 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Sibling	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)

Other Household 1	Other	Alleged Perpetrator	Male	34 Year(s)

LDSS Response

Following the receipt of the report on 4/4/16, LE informed ACS that they received a 911 call at 1:44 PM and responded to the home at 1:50 PM. At the time LE responded to the case address, the medical service unit was in the home, the child was already dead and rigor mortis had set in. LE said the child was left in the care of the adult female half sibling (AFHS) while the SM completed errands. The AFHS had preexisting health conditions and it was unclear whether she had the ability to supervise the child.

On 4/5/16, the parent substitute (PS) informed ACS that he was in the home during the incident. He said he visited the home to help the SM with the 2-year-old half sibling. According to the PS, the 12-year-old child woke at about, 4:00 AM, he stood nearby the SM's bed, and the SM told him to return to sleep. The PS went to the living room to sleep on the sofa and during the morning of 4/4/16, he observed the SM left the home to complete errands. The PS said the 12-year-old child and AFHS remained asleep. The PS supervised the 2-year-old half sibling while the mother was out of the home. After the mother returned home, she checked the 12-year-old child, observed he was not breathing and then informed the PS. Then the PS observed the child facing the wall face down in the pillow. He turned him over and saw the child was gray, cold, and his arms were folded under his chest. He had to charge his phone before they called 911 as both his and the SM's phones were dead. The 911 operator asked the PS to perform CPR and he told them the child was already dead. The PS was aware an OOP had existed but he believed it expired.

On 4/5/16, ACS spoke with the ME who said the child had a small bruise an eighth of an inch on the tongue and half inch bruise on the right elbow consistent with history of the medical condition. There was no evidence or suspicion of child abuse. Later, the ME explained that people who have the pre-existing medical condition and who use medication as prescribed could still die. Even if there were low levels of medication and/or the SM did not provide the child with the medication as prescribed, the ME would not be able to attribute the child's death directly to the lack of medication.

On 4/6/16, a conference occurred. The AFHS said the SM told her to check the child, she went into the room and saw that he was asleep with his face turned to the wall. She did not touch him and she exited the room. She informed ACS that she used her prescribed medication but discontinued using the medication two weeks prior to 4/4/16. The AFHS admitted to drug misuse. The SM informed ACS that in September 2015, she completed her health evaluation, she was prescribed medication but she did not use the prescribed medication.

On 4/7/16, the Dr.'s office informed ACS that the child had a medical examination on 12/17/15. The Dr. ordered testing and prescribed three medications. The child was referred for a medical procedure and was given appointments (12/22/15 and 3/11/16); both times the child was not in attendance. The Dr. confirmed the child's medical diagnosis. The Dr.'s office noted there was a specific phenomenon of sudden death associated with the child's symptom related to the diagnosis.

On 6/9/16, the ME informed ACS of findings related to the child's symptoms. The ME said this was an important finding as the child's Dr.'s did not know the reason for the child's particular symptom. According to the ME, the cause of death was unknown. The ME explained that no one was able to state whether the child had experienced specific symptoms on 4/4/16. The ME added that there was "no high index of suspicion" regarding the possibility that the child was smothered.

On 6/13/16, ACS met with the PS who agreed to attend parenting classes and random drug testing. The PS said he believed that the SM wanted to drop the OOP against him. He was encouraged to discuss the OOP with his attorney.

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 investigations.

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.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
029901 - Deceased Child, Male, 12 Yrs	029903 - Sibling, Female, 19 Year(s)	Inadequate Guardianship	Pending
029901 - Deceased Child, Male, 12 Yrs	030081 - Other - Parent Substitute, Male, 34 Year(s)	DOA / Fatality	Pending
029901 - Deceased Child, Male, 12 Yrs	030081 - Other - Parent Substitute, Male, 34 Year(s)	Inadequate Guardianship	Pending
029901 - Deceased Child, Male, 12 Yrs	029902 - Mother, Female, 40 Year(s)	DOA / Fatality	Pending
029901 - Deceased Child, Male, 12 Yrs	029902 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Pending
029901 - Deceased Child, Male, 12 Yrs	029903 - Sibling, Female, 19 Year(s)	DOA / Fatality	Pending
030681 - Sibling, Female, 2 Year(s)	029902 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Pending
030681 - Sibling, Female, 2 Year(s)	029903 - Sibling, Female, 19 Year(s)	Inadequate Guardianship	Pending

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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☐	☐	☒
School	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
Documentation did not reflect that ACS interviewed the school staff or the child's Dr.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
On 4/6/16, ACS filed an Article Ten Neglect Petition in KCFC on behalf of the 2-year-old surviving half sibling naming the SM and PS of the as respondents. The Family Court granted remand of the 2-year-old half sibling.

Legal Activity Related to the Fatality

Was there legal activity as a result of 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:**
04/06/2016	There was not a fact finding	There was not a disposition
Respondent:	029902 Mother Female 40 Year(s)	

Comments:	ACS filed an Article Ten Petition on 4/6/16 on behalf of the 2-year-old surviving half sibling naming the SM and PS as respondents.

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:
Documentation reflected that the 2-year-old surviving half sibling received Early Intervention Services at home. On 4/8/16, ACS referred the mother for services including grief counseling, alcohol screening/drug testing, parenting classes, anger management and DV counseling.

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:

The 2-year-old surviving half sibling was placed in foster care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS referred the mother for services including: grief counseling, alcohol screening/drug testing, parenting classes, anger management and DV counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	Yes
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

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)
04/13/2015	10233 - Sibling, Female, 1 Years	10231 - Mother, Female, 39 Years	Inadequate Guardianship	Indicated	Yes
	10234 - Deceased Child, Male, 11 Years	10231 - Mother, Female, 39 Years	Inadequate Guardianship	Indicated	
	10233 - Sibling, Female, 1 Years	10232 - Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10233 - Sibling, Female, 1 Years	10231 - Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10234 - Deceased Child, Male, 11 Years	10231 - Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10233 - Sibling, Female, 1 Years	10232 - Father, Male, 33 Years	Inadequate Guardianship	Indicated	
	10234 - Deceased Child, Male, 11 Years	10232 - Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10234 - Deceased Child, Male, 11 Years	10232 - Father, Male, 33 Years	Inadequate Guardianship	Indicated	
Report Summary:					

The 4/13/15 report alleged that the home was in deplorable condition and a health and safety hazard for the 11-year-old and one-year-old children. There was old food and garbage strewn throughout the home and accessible to the children. There was cat urine all over the home. The mother and father are aware of the safety concerns and did not rectify the situation. The situation was ongoing.

Determination: Indicated	**Date of Determination:** 06/10/2015

Basis for Determination:
ACS based the determination on the findings that the mother placed the 1-year-old child on the bed and the child subsequently fell off the bed. The child did not sustain any injuries but was transported to the hospital. The parents said the home was messy and full of cat urine. The parents admitted they had been arguing in the children's presence when the one-year-old child fell off the bed. The parents were aware that there was an active order of protection (OOP) and they proceeded to violate the OOP. This could potentially expose the children to domestic incident between the parents and it placed the children at risk. The home was disorganized not deplorable.

OCFS Review Results:
ACS initiated the investigation within the required timeframe. The 7-Day safety assessment for the 4/13/15 report was not completed within the required timeframe as it was completed on 4/23/15. ACS staff discussed safe sleep with the SM. ACS staff interviewed the Puerto Rican Family Institute (PRFI) CP. The CP reported that the SM was compliant with services and PRFI planned to close the case. The service plan included individual and family counseling, medical and education services for the 12-year-old child. The SM stated the child had preexisting medical conditions and developmental disability. The child was administered prescribed medication and he wore a medical device in school.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
For the report dated 4/13/15, ACS did not complete the 7-day safety assessment within the required timeframe. ACS completed and approved the 7- Day safety assessment on 4/23/15.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(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 child (deceased) was known to the SCR and ACS in a report dated 12/6/07. The allegations of the 12/6/07 report were IG of the child and IG, XCP, and L/B/W of the male half sibling (now adult) by the child's father. The report was unfounded. The child was also known in a report dated 12/17/10. The allegations of the report were IG and IF/C/S; the report was unfounded.

The SM was known in four reports: 3/17/08 (two reports), 5/3/08 and 7/27/10. The allegations of the 3/17/08 reports were IF/C/S, IG, LS, and M/FTTH of the child and his male half sibling (now adult) and LS of the female half sibling (now adult) by the SM. The 5/3/08 report was consolidated with the 3/17/08 investigation. On 5/16/08, ACS substantiated the allegations of IF/C/S, LS and IG and the agency unsubstantiated the allegation of M/FTTH. The allegations of the 7/27/10 report were IG, PD/AM, and XCP of two children (now adults) by the SM. The allegations of XCP and IG were

substantiated, and PD/AM was unsubstantiated.

The parent substitute (PS) was known in three reports dated 10/24/06, 2/21/07, and 4/17/07. The allegations of the 10/24/06 report were IG, MN and PD/AM. On 1/10/07, ACS substantiated the allegation of IG and PD/AM and unsubstantiated the allegation of MN. The allegations of the 2/21/07 report were IF/C/S, IG and PD/AM of the three children. The report was indicated. The allegation of the 4/17/07 report was Other. ACS unsubstantiated the allegation. The 4/17/07 report was Unfounded.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Required Action(s)

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The Puerto Rican Family Institute documentation did not reflect that the child's (deceased) medical provider's were interviewed despite having a medical condition.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
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.

Preventive Services History

During the 12/6/07 investigation, ACS referred the family for PPRS with the New York Urban League (NYUL) agency on 12/19/07. The family started services with NYUL on 1/3/08. The family received counseling and case management services. During the 3/17/08 investigation, ACS filed an Article Ten Neglect Petition in Kings County Family Court (KCFC) on 3/27/08. ACS requested court ordered supervision (COS) and the child and female half sibling (now adult) were paroled to the child's BF. The family received Family Preservation Program (FPP) services.

On 11/13/08, the family was referred to Family Consultation Services agency for PPRS. The CP accompanied the SM to the hospital to ensure she received treatment. The CP coordinated services with the Steinway Child and Family Services agency. The SM attended the EDNY Drug Treatment Center and the child received medical services.

The family was referred to PPRS on 9/7/13. The 7/31/15 FASP reflected the SM received community based services but was non compliant. She completed a program for alcohol misuse with Samaritan Village. On 6/12/15, the CP referred the SM to community based services. The last home visit was conducted on 12/1/15. The Puerto Rican Family Institute (PRFI)did not observe the PS in the home. PRFI closed the case on 12/10/15 on the basis that the SM provided the children's needs.

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: 12/18/2013	**To:** 12/17/2018
Explain: There was a full stay away OOP against the PS regarding the mother. The OOP effective dates were 12/18/13 to 12/17/18. The OOP was issued in Criminal Court.	

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