Child Fatality Report

Report Identification Number: NY-18-026

Prepared by: New York City Regional Office

Issue Date: Sep 10, 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: 15 year(s)
Jurisdiction: New York
Gender: Female
Date of Death: 03/14/2018
Initial Date OCFS Notified: 03/14/2018

Presenting Information

On 3/14/18, OCFS was notified by a preventive services agency, Jewish Board of Families and Children's Services (JBFCS) of the child's (SC) death. Per the notification, the BM phoned the Case Planner (CP) on 3/12/18 informing that an incident occurred at the SC's school. That school officials reported to her the SC was standing with two friends in the hallway when she fell backwards unconscious; her head struck the ground and she began seizing. The school officials initiated their emergency code and the SC was attended to by the school nurse and a Montefiore medical doctor who was present in the school. The SC was identified as not having a pulse and a defibrillator was used several times to restart her heart. The SC's heart did not restart and she was transported by EMS to Montefiore Medical Center. There, the SC's heart would not restart; she was rushed into surgery where she was placed on life support. The SC's heart never restarted and she died on 3/14/18 at 11:46am.

Executive Summary

The Certificate of Death issued by the NYC Department of Health and Mental Hygiene, listed the child's (SC) date of death as 3/14/18. Immediate cause of death: Pending Further Studies. The office of the Chief Medical Examiner conducted an autopsy of the SC on 3/15/18. Per the autopsy report issued on 6/6/18, the cause of death was Undetermined; the manner of death was Natural.

The SC's wake occurred on 3/18/18, and internment occurred on 3/19/18.

There was no SCR report regarding the SC's death; therefore, there was no CPS investigation.

Voluntary agency, JBFCS Trauma Systems Therapy (TST) preventive program provided services (PPRS) to the family beginning 9/27/17 to date.

After the SC's death on 3/14/18, the TST Case Planner (CP) conducted a home visit (HV) and safety assessment of the surviving sibling (SS) on 3/20/18. The CP provided ongoing supportive counseling and case monitoring services to the SS and BM. This occurred via face to face contacts at least twice a month. Referral for bereavement counseling with a community based provider was provided to the BM who confirmed intake appointment on 5/16/18. There was no record/reference to the SS's biological father or of attempts to engage him although he remained listed in the case composition.

The TST CP assessed there were no safety factors/issues for the SS, risk was low and that the BM had a strong protective capacity. Therefore, a Service Termination Conference (STC) was scheduled and held on 6/13/18 (documented on 7/16/18). Present at the STC were the CP, CP supervisor, BM and SS. During the STC, there was mutual agreement regarding case closure. However, the case remains open with JBFCS' TST program and in CONNECTIONS, without documentation whether risk factors emerged for the SS necessitating the case to remain open.

PIP Requirement
NA

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
N/A

Was the decision to close the case appropriate? 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:
JBFCS TST conducted a Service Termination Conference (STC) with the family on 6/13/18. However, the case remains open in CONNECTIONS with no documentation of emerging risk and/or safety factors/concerns for the SS.

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: 03/14/2018 **Time of Death:** 11:46 AM

Date of fatal incident, if different than date of death: 03/12/2018
Time of fatal incident, if different than time of death: 10:45 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 10:49 AM
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: Talking

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: 01
Adults: 00

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	15 Year(s)
Deceased Child's Household	Mother	No Role	Female	38 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Stepfather	No Role	Male	51 Year(s)

LDSS Response

Per documentation, on 3/12/18 the TST CP received a phone call from the biological mother (BM) who informed school officials contacted her stating that her 15-yr-old child (SC) reportedly had a seizure, fell and was unresponsive. The school nurse and a doctor visiting from Montefiore hospital used a defibrillator to restart her heart. EMS arrived at the SC's school in response to a 911 call and began CPR. They applied AED and was advised to shock 3 times; the SC remained pulseless. EMS transported her to the hospital ER; the SC was in Cardiac Arrest. She was immediately rushed to surgery, continued to have cardiac and circulatory failure, and was placed on life support.

On the same date, the TST Program Director (PD) received a phone call from the hospital social worker who informed there was an emergency with the family. The PD then met the CP already present at the hospital. There, the hospital social worker informed both that the SC was in ICU on a machine to help her heart as it was not working.

Per documentation, the BM was in the ER with two school officials who provided detailed information to the CP regarding the incident that resulted in the SC being hospitalized. The CP and BM then spoke with the surgeon who informed they were unable to get the SC's heart working and she was on a machine. The CP asked the BM who would collect the SS from school and BM said a family friend would until her BF returned home from work.

On 3/13/18 at 8:49am, the BM phoned the CP informing that the SC's doctor stated she was ‘brain dead’. On 3/14/18, the BM phoned the CP saying the SC had died. The CP then made hospital visit to support the BM. There, the CP asked the hospital social worker if they provided funeral expense assistance; they did not. The CP asked the BM if she needed assistance telling the SS of the SC's death; BM said no.

On 3/16/18 the PD internally requested funeral expenses assistance. Payment was issued to the funeral home and confirmed. On 3/18/18 the PD and CP attended the SC's wake. The BM and school personnel were seen. When asked, the BM reported that the SS was doing well. The BM was receptive to bereavement counseling ‘when things settled down’.

On 3/19/18 an Elevated Risk Conference (ERC) that was requested on 2/23/18 per PNs, was held with TST and ACS staff. It was noted the SC had a physical exam 2 weeks prior to her death; no medical concerns were identified.

On 3/20/18 the CP conducted a home visit (HV) with the BM and SS. This is the first recorded conversation with the 9-yr-old SS since PPRS began as well as first contact since the SC died. At the 4/5/18 HV with the BM and SS, the CP gave BM a referral for bereavement counseling. At the 4/12/18 HV with the BM and SS, the CP engaged the SS and assessed the home environment. The BM informed the CP bereavement counseling intake was scheduled on 5/16/18. At the 4/30/18 HV by the TST Supervisor with the BM and SS who was observed, the BM was given a referral to JBFCS' psychiatrist for an evaluation following BM reporting side effects from medication given to her by Montefiore hospital following the SCs death; BM went to the ER re same and they discontinued the medication.

On 5/11/18, the CP made a school visit (SV) and met with the SS and her guidance counselor. The BM was informed via phone, of the school visit. On 5/16/18, the BM phoned the CP stating that the SS failed the city testing and would be held back to repeat the 3rd grade. The CP conducted a SV on 5/18/18 with the guidance counselor and another SV on 5/25/18 with the SS' teacher who informed the SS would not be held back but needed Math tutoring; BM was informed.

On 6/13/18, the CP & Supervisor conducted a STC with BM and the SS in the home. At 6/26/18 HV, the BM gave a copy of the SCs autopsy report to the CP and said results were pending from genetic testing done to rule of her as carrier of heart disease. The PPRS case remains open with JBFCS to date.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: No fatality review was required in association with the child's death.

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:
N/A

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:
The first recorded contact the CP had with the SS following the SC's death was on 3/20/18 during a home visit.

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The family was receiving PPRS services prior to and post the SC death.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine

Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☐	☒	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: There was no SCR report or CPS investigation associated with the SC's death.				

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: N/A							

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 CP conducted HV and assessed the SS on 3/20/18. Subsequent HVs occurred as required with the SS and BM. The CP also conducted school visits with the SS, her guidance counselor and teacher to discuss the SSs academic performance and promotion concerns/status.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
PPRS continued with casework counseling, academic assistance and case management services. The CP provided emotional and other resource support. The CP met the BM at the hospital during critical care of the SC, and attended the SC's wake. The program director internally requested funeral expense assistance and JBFCS paid $4,000.00 to the funeral home. The BM was referred for Bereavement Counseling. There were no recorded attempts regarding engaging the SSs BF.

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?	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

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)
06/02/2017	Deceased Child, Female, 14 Years	Mother, Female, 38 Years	Excessive Corporal Punishment	Unsubstantiated	No
	Deceased Child, Female, 14 Years	Mother, Female, 38 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 14 Years	Mother, Female, 38 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
Per the call narrative, on 6/1/17 the BM was physically aggressive towards the 14-year-old SC. The BM beat the SC because she was up late doing homework. Thus, the SC sustained lacerations to her leg. This was done as a form of punishment. The step-parent and SS had unknown roles. Miscellaneous information stated that the police got involved regarding this incident. That the SC emailed her teachers stating she was not going to be in school because of the incident; she showed up to school around 2PM that day. It was unknown if the BM was under the influence. Details of past police involvement were unknown. The child also had a cut on her nose; it was unknown where the injury came from.

Report Determination: Unfounded	**Date of Determination:** 08/03/2017

Basis for Determination:
CPS investigated the allegations of XCP and L/B/W against the BM on behalf of SC. CPS found no credible evidence to prove/support the allegations and concluded they were Unsub. Per documentation, the BM said she called the police trying to prevent the SC from leaving the home past her curfew. The SC left the home and when upon her return the BM refused her entry, called the police. The police showed and told BM she had to let the SC in. The SC admitted fabricating the account of her and BMs altercation; that BM did not hit her as a form of punishment. When CPS observed the SC for marks or bruises, a scratch was observed on her nose; she said she got it in a fight at school.

OCFS Review Results:
CPS' investigation included interviews with the subjects of the report, collaterals and family members. CPS also referred the BM for a random toxicology screening; the results were negative. CPS documented BM had difficulty controlling the SCs behavior. That there was some improvement but BM continued to struggle with the SCs defiant behavior. Therefore, CPS discussed PPRS with the BM who agreed to same. The SC would not agree to PPRS, saying she was 'not comfortable having people in my business'. CPS appropriately referred the family for PPRS.

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)
12/09/2016	Deceased Child, Female, 14 Years	Mother, Female, 38 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 14 Years	Mother, Female, 38 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
Per the call narrative, on 12/7/16 the BM and 14-year-old SC got into a verbal argument. The BM became extremely frustrated and hit the SC multiple times about her body. Thus, the SC sustained a red mark and scab on her elbow. It was unknown why this happened and what BM hit the child with. BM then threw the SC's back pack, hard enough to break a bottle of nail polish that was in the bag. The role and name of 7-year-old SS was unknown.

Report Determination: Unfounded **Date of Determination:** 02/07/2017

Basis for Determination:
The investigation conclusion stated that the allegations of IG & L/B/W against the BM for the SC were Unsub. That CPS found no credible evidence to support the allegations. CPS did not observe any signs that the SC was abused as reported to the SCR. The SC reported to CPS the BM may hit her with an open hand but not in a manner to abuse her. The SC had no signs of abuse or maltreatment throughout the investigation. CPS observed the SC to be well cared for and the BM was more than meeting the SC's needs. The home environment was safe and comfortable for the SC. The SC reported there was food and her medical needs were being met.

OCFS Review Results:
The family's CPS investigation history prior to the 12/9/16 SCR report showed SUB allegations of L/B/W for the SC by the BM on two occasions. For this investigation, the CPS documented in the investigation determination that the SC reported the BM hit her with an open hand but not in a manner to abuse her. This was not fully explored by CPS. However, the CPS appropriately conducted collateral contacts that included school personnel and family members.

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

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

An SCR report of 6/5/07 alleged PDRG by the BM against the SC. CPS' INV concluded as UNF on 6/29/07.

The BF filed for custody of the SC on 8/13/08, and alleged BM abused alcohol and the SC. On 10/21/08 Bronx Family Court ordered ACS to conduct a Court Ordered Investigation (COI) and submit written report on 12/4/08. ACS

investigated & submitted the court report on 12/4/08.

A 10/11/11 report alleged IG & SXAB of the SC by her BF; the BM and SS had no role. The SC was interviewed at a CAC on 10/21/11. On 11/17/11, ACS filed an Article X petition against the BF. The Court paroled the SC to her BM, ordered ACS' COS of the family, ACS to supervise visitation between the BF and SC, & issued an OOP against the BF on behalf of the SC. The SC was referred to a CBO for SXAB counseling. ACS provided COS monitoring of the family from 11/16/11 to 12/20/13. At a 12/18/13 hearing, the BF withdrew his visitation petition. The Court dismissed ACS' Article X petition against the BF without prejudice, and granted BM full custody of the SC.

A 9/21/15 report alleged IG, L/B/W & PDRG by the BM against the then 13-year-old SC. The SS was not included in the reports' List of Principals. CPS' INV concluded on 11/23/15 as IND. The family was referred to a CBO. Add Info of 9/22/15 reported the SC was sexually involved with a 42-year-old male; law enforcement was involved.

A 10/18/15 report alleged IG, L/B/W, & PDRG of the SC by the BM; L/B/W was SUB. The report was IND and closed on 12/8/15.

Known CPS History Outside of NYS

The family has no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 08/02/2017

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: 08/02/2017

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 Reassessment FASP due date was 3/5/18. It was approved on 3/15/18.				
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:
Preventive services agency, JBFCS Trauma Systems Therapy (TST) program was assigned Caseworker on 9/27/17, and Case Planning responsibility for the family on 10/26/17. Currently, the case remains active/open.

Required Action(s)

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

Issue:	Timeliness of completion of FASP
Summary:	The Reassessment FASP due date of 3/5/2018, was approved on 3/15/2018.
Legal Reference:	18 NYCRR428.3(f)
Action:	ACS must submit a corrective action plan to OCFS within 45 days regarding its actions to address the identified issue. ACS must include its policies regarding FASP timeliness for its' contracted service providers. ACS must ensure that JBFCS TST meet with staff to address this issue, and inform OCFS of the date of the meeting, who attended, what was discussed, and the action plan.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	From date of case opening with JBFCS TST program, there were no documented supervisory Progress Notes (PNs) until 3/12/18. Subsequent PNs were recorded 30+ days late. Also, PNs generally were not documented contemporaneously by the TST CP.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a corrective action plan to OCFS within 45 days regarding its actions to address the identified issue. ACS must include its policies for Progress Notes documentation by preventive case planners and supervisors. ACS must ensure that JBFCS TST meet with staff to address this issue, and inform OCFS of the date of the meeting, who attended, what was discussed, and the action plan.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	JBFCS TST did not document qualitative casework contacts or that service needs were assessed for the 9-yr-old SS from date of case responsibility up to when the SC died. There were no attempts to engage the SS's BF included in the case composition.
Legal Reference:	432.1 (o)
Action:	ACS must submit a corrective action plan to OCFS within 45 days regarding its actions to address the identified issue. ACS must include its policies for engaging fathers and for engaging preventive

	services recipient children. ACS must ensure that JBFCS TST meet with staff to address this issue, and inform OCFS of the date of the meeting, who attended, what was discussed, and the action plan.
Issue:	Adequacy of case planning
Summary:	JBFCS TST assessed there were no safety concerns or emerging risk for the SS and convened a Service Termination Conference on 6/13/18. The case remains open in CONNECTIONS without documented justification in adherence with 18 NYCRR 423.2(b).
Legal Reference:	18 NYCRR 432.2 (b)(2)
Action:	ACS must submit a corrective action plan to OCFS within 45 days regarding its actions to address the identified issue. ACS must include its policies for assessing eligibility for preventive services case closure. ACS must ensure that JBFCS TST meet with staff to address this issue, and inform OCFS of the date of the meeting, who attended, what was discussed, and the action plan.

Preventive Services History

During the investigation of a 6/2/17 SCR report, CPS assessed the family would benefit from preventive services to address the SC's acting-out behaviors and communication issues with the BM. No service need was assessed for the SS. JBFCS' Trauma Systems Therapy (TST) preventive program accepted CPS' referral per 9/15/17 PN. A joint home visit occurred with CPS and TST Case Planner (CP) on 10/3/17 during which the BM & SC signed for services (PPRS).

Before the SC's death, the TST CP did not document engagement with, or a service need assessment of the SS. The SS was observed at home visits. There was no documentation re the SC's stepfather who was in the Case Composition. Also, prior to 3/12/18 no JBFCS supervisory PNs were documented.

The CP successfully engaged the SC during casework counseling sessions. The CP made school and collateral contacts with and on behalf of, the SC. This included assisting the SC with obtaining a school safety transfer. The CP discussed domestic violence and safety following BM reporting observing bruising on the SC on more than one occasion for which the SC's explanations were suspicious; BM suspected DV was occurring between the SC and her boyfriend. The CP informed the BM an ERC was scheduled to address this concern at a 3/8/18 HV. Unfortunately, the SC passed away before the ERC convened. JBFCS continues to provide PPRS to the family.

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

Additional Local District Comments

N/A

Recommended Action(s)

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

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