Child Fatality Report

Report Identification Number: NY-18-063

Prepared by: New York City Regional Office

Issue Date: Dec 06, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 04/11/2018
Initial Date OCFS Notified: 06/13/2018

Presenting Information

The 5-month-old male infant was in the hospital when he died on 4/11/18. The infant was hospitalized for treatment of multiple illnesses from the time of his birth. He was never discharged to the BM's care.

Executive Summary

The 5-month-old male infant died on 4/11/18. The infant was in the hospital at the time of death and was pronounced dead by a hospital attending physician. ACS case record reflected the death was due to natural causes.

At the time of the infant's death, the family had an open preventive services case. ACS opened the case on 11/15/17 after the agency found the BM did not adequately supervise the sibling and half-sibling. The BM gave birth to the infant in early November 2017, and the infant was admitted to the hospital at birth. He was not expected to be released to the BM. The BM stated she was overwhelmed with child care responsibilities and requested support services.

ACS obtained and reviewed medical records pertaining to the infant's death. ACS findings showed that during the BM's pregnancy, medical staff informed her the infant was not expected to survive. ACS also found the infant was born at 31 weeks gestation and tested positive for methadone at birth as the BM attended methadone program. The attending physicians diagnosed the infant had respiratory distress and numerous medical complications associated with prematurity. The infant's medical treatment plan included discharge from the hospital to a long-term rehabilitation facility. Initially, his medical condition was stabilized; however, he experienced respiratory complications, his condition deteriorated, he had no auditory breath and no pulse, and was pronounced dead on 4/11/18.

ACS submitted the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Cases. The information regarding the infant’s death was reported to OCFS under Chapter 485 of the Laws of 2006.

Following notification of the infant’s death, ACS did not assess safety of the SS and half-sibling until 6/7/18. During the 6/7/18 home visit, ACS assessed there were no safety factors that placed the sibling and half-sibling in immediate danger. There was no discussion pertaining to the infant's death, burial and bereavement.

ACS monitored the family through home visits and telephone contacts. ACS referred the family for PPRS and the BM accepted the referral. The PPRS case was open at the time of issuance of this fatality report.

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:
The casework activity was commensurate with regulatory requirements.

Required Actions Related to the Fatality

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

Issue:	Required data and official documents
Summary:	The ACS case record did not reflect whether the agency obtained official records, including death certificate, to verify the time the infant was pronounced dead and the cause and manner.
Legal Reference:	428.3(b)(2)(i)
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/11/2018 **Time of Death:** 05:15 AM

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? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	5 Month(s)
Deceased Child's Household	Father	No Role	Male	27 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

Following the infant's death, ACS interviewed the hospital staff about the case circumstances on 4/11/18. According to the hospital staff, the infant was pronounced dead on 4/11/18 at 5:15 AM. The BM, BF, and MGM were in the hospital at the time of the infant's death. The hospital offered the family bereavement for support group and the BM agreed to follow up.

Between 4/17/18 and 6/4/18, ACS attempted to visit the home and establish telephone contact with the family; however, the BM did not respond. On 6/5/18, the BM agreed to a scheduled home visit. The scheduled home visit occurred on 6/7/18. The progress notes for the 6/7/18 visit reflected the home was disorganized. ACS observed the SS and half-sibling and noted they did not have visible marks/bruises. The documentation did not include discussion about the infant's death, burial, and bereavement for the family.

ACS maintained contact with the BM and addressed the benefits of preventive services. ACS engaged the BM, SS, and half-sibling in the home, assessed the home environment and completed ongoing safety assessments and risk assessments. ACS provided referral for day care services for the SS. The half-sibling received counseling to address his behavior concerns in school. He was subsequently promoted to the next grade. In July 2018, the BM signed an agreement to receive PPRS with University Behavioral Associates agency (UBA). The progress notes reflected UBA monitored the BM's engagement with her methadone maintenance program. The BM received bereavement during scheduled sessions. The documentation showed that during the sessions, the BM was well engaged and open about her grief.

According to the UBA case record, the BM tested positive for opiates in toxicology screens that occurred on 8/6/18 and 8/16/18, respectively. The BM acknowledged she misused opiates while engaged with her methadone maintenance program.

On 8/16/18, the SCR registered a report regarding the family. ACS investigated the report and on 10/15/18, ACS substantiated the allegations of IG and PD/AM of the SS and half-sibling by the BM on the basis the BM did not obtain mental health services for herself and the half-sibling. ACS added that the BM tested positive for opiates while engaged in a methadone maintenance program.

On 9/10/18, UBA contacted Montefiore Children's Hospital and inquired about the BM's request for an autopsy for the

infant. The hospital agreed to follow up with the BM. The case record did not include additional information to determine whether there was an autopsy for the infant.

On 10/30/18, the UBA, ACS, BM, MA participated in an Elevated Risk Conference to address risk concerns. The participants discussed the BM's misuse of an illicit substance, her failure to attend scheduled mental health sessions and the half-sibling's recent excessive school absences. As a result of the conference, the BM scheduled mental health related appointments for herself and the half-sibling and she agreed to contact her physician to discuss appropriate medication.

On 11/8/18, the SCR registered a report that included the allegation of PD/AM of the SS and half sibling by the BM and BF. ACS was in the process of investigating the 11/8/18 report at the time of issuance of this fatality report.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
The infant was hospitalized and never released to the parents. There was no LE involvement with the fatality.

ACS did not enter progress notes contemporaneously, including an event that occurred on 1/9/18 that was not entered until 4/11/18.

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: ACS did not make diligent efforts to visit the family within 7 days of notification of the infant's death.				

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 BF did not make himself available for services and ACS was unable to gather updated information to assess his role as a Secondary Caretaker for the SS and half-sibling.				

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 were no safety factors that placed the children in immediate danger and, therefore; no safety interventions were required.

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:
The family received PPRS. The documentation showed the SS did not need Early Intervention services.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:

ACS monitored the half-sibling's academic attendance and followed up to ensure the BM obtained the child care voucher for the SS. The half-sibling received counseling in school. ACS provided supplies and addressed sleeping arrangements for family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The BM received casework counseling, referral for bereavement, drug treatment and household supplies. The BF agreed to participate in the service plan implementation; however, he did not accept drug treatment screening and case management services.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/10/2017	Sibling, Male, 10 Years	Father, Male, 27 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Female, 1 Years	Father, Male, 27 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 10 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	

Sibling, Female, 1 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 10 Years	Mother, Female, 29 Years	Educational Neglect	Substantiated
Sibling, Male, 10 Years	Father, Male, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 1 Years	Father, Male, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 10 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 1 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 10 Years	Father, Male, 27 Years	Lack of Supervision	Substantiated
Sibling, Female, 1 Years	Father, Male, 27 Years	Lack of Supervision	Substantiated
Sibling, Male, 10 Years	Mother, Female, 29 Years	Lack of Supervision	Substantiated
Sibling, Female, 1 Years	Mother, Female, 29 Years	Lack of Supervision	Substantiated

Report Summary:
The 11/10/17 SCR report alleged the BM was hospitalized in November as she had a newborn infant. The infant had some complications from low birth. The BF was supposed to supervise the 10-year-old half-sibling and 1-year-old SS; however, he was not in the home as he was in the hospital. The half-sibling and SS were home alone. The BF expected the half-sibling to take care of the SS: the half-sibling was not able to care for a 1-year-old child. The half-sibling missed school because he was babysitting. There was no food in the home. The SS had a burn on her wrist, unknown how it happened.

Report Determination: Indicated | **Date of Determination:** 01/18/2018

Basis for Determination:
ACS substantiated the allegations of EdN of the half-sibling by the BM and IG and LS of the SS and half-sibling by the BM and BF on the basis the half sibling had excessive school absences, the BM did not provide documentation to excuse the excessive absences and the half-sibling failed academically. ACS explained that the SS and half-sibling were left unsupervised in the home.

ACS unsubstantiated the allegation of IF/C/S on the basis of no credible evidence to support the allegation.

OCFS Review Results:
ACS observed the BM and SS in the home on 11/14/17. ACS interviewed the BM and BF and they both denied they left the SS and half-sibling unsupervised. The BF said he did not reside with the BM and he acknowledged he visited the home, supervised the children and supported the BM. ACS monitored the family and learned there was no adult in the home at the time the BM allowed the half-sibling to supervise the SS.

ACS addressed adequacy of sleeping arrangement, counseled the BM about safe sleep practices and assisted with obtaining furniture. ACS visited the hospital and verified the infant was in critical health and required long term medical care.

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)
05/03/2017	Sibling, Male, 10 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 10 Years	Mother, Female, 28 Years	Educational Neglect	Unsubstantiated	

Report Summary:
The 5/3/17 SCR report alleged the half-sibling had excessive school absences. The report stated that the half-sibling had fallen behind academically. When the half-sibling attended school he fell asleep during classes because he stayed up late playing. The BM was aware but failed to ensure the half-sibling's attendance improvement.

Report Determination: Unfounded | **Date of Determination:** 07/03/2017

Basis for Determination:
ACS unsubstantiated the allegations of EdN and IG of the half-sibling by the BM on the basis the half-sibling was promoted in school. ACS noted the BM provided documentation that addressed the reason for the school absences and related issues.

OCFS Review Results:
The BM denied the allegations of the report. Initially, the BM did not allow ACS entry and ACS observed the SS and half-sibling at the door of the home. ACS interviewed the half-sibling and staff in the school on 5/9/17. ACS verified the half-sibling had excessive school absences. ACS observed the SS and half-sibling in the home and noted they did not have marks/bruises on 6/30/17. As a result of ACS intervention, the BM contacted school officials and complied with the school's requests. ACS contacted the school and verified the half-sibling was promoted to the next grade.

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)
12/15/2016	Other Child - Cousin, Male, 17 Years	Father, Male, 26 Years	Childs Drug / Alcohol Use	Unsubstantiated	Yes
	Other Child - Cousin, Male, 17 Years	Mother, Female, 28 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Sibling, Male, 9 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 9 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 12/15/16 SCR report alleged the BM and BF (father of the infant and SS) allowed the 17-year-old cousin to smoke marijuana to impairment in the home. The cousin wore the half-sibling's clothing and put items, which were used to wrap marijuana, inside the half-sibling's pants pocket. On 12/15/16, the half-sibling wore the pants to school and had drug paraphernalia in his possession.

Report Determination: Unfounded | **Date of Determination:** 02/09/2017

Basis for Determination:
ACS unsubstantiated the allegation of CD/A of the cousin by the BM and BF on the basis the BM was not the caretaker or person legally responsible for the cousin. ACS added that the agency did not establish contact with the cousin as the cousin was incarcerated.

ACS unsubstantiated the allegation of IG of the half-sibling by the BM on the basis of no credible evidence to support the allegation. ACS unsubstantiated the allegation of IG of the half-sibling by the BF as the BF was not the caretaker or person legally responsible for the half-sibling.

OCFS Review Results:
ACS interviewed the BM and half-sibling and observed the SS. ACS findings showed the children did not have marks/bruises.The BM denied the allegations as she said someone placed dried leaves in the half-siblings clothing. ACS verified the half-sibling had the dried leaf substance that reportedly belonged to the cousin. ACS safety assessments showed there was no safety factor that placed these children in immediate danger.

ACS learned that the BM, BF and cousin smoked marijuana in the home. The half-sibling had multiple school absences and lateness. ACS failed to contact the cousin, interview the BF, address the half-sibling's school needs, and add the allegation of PD/AM to the report.

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

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
ACS investigation of the 12/15/16 report was incomplete as the agency did not obtain adequate information to determine the extent of drug use in the home and impact on the care the BM and BF provided the SS and half-sibling. The family experienced hardship in transporting the half-sibling to school; however, there was inadequate information about the BM's efforts to address the school attendance.

Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(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.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
ACS did not make diligent efforts to contact the 17-year-old subject child/who was listed in the 12/15/16 report. The documentation showed the child was incarcerated and there was inadequate efforts to contact his parents or guardian, or other persons legally responsible for the child.

Legal Reference:
18 NYCRR 432.1 (b)(3)(ii)(a)

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.

[redacted]

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

The BM was known as a subject in a SCR report dated 10/20/14. The allegations of the report were EN, LS and PD/AM of the male half-sibling by the BM. On 12/29/14, ACS unsubstantiated all the allegations of the report on the basis the BM provided the male half-sibling with a minimum degree of care.

Known CPS History Outside of NYS

The family had 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: 11/15/2017

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: 11/15/2017

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?	☒	☐	☐	☐
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: ACS provided case management services to the family.				

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	ACS did not enter Family Services Progress Notes contemporaneously, including an event that occurred on 1/9/18 that was not entered until 4/11/18.

Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this case and inform NYCRO of the date of the meeting, who attended and what was discussed.

Preventive Services History

During the 11/10/17 investigation, ACS found the BM did not provide adequate supervision of the half-sibling and SS, and did not address the half-sibling's educational needs. ACS opened a preventive services case for the family on 11/15/17. The family received case management that included ACS staff visiting the school to monitor the half-sibling's attendance and academic performance, providing day care referral for the SS and monitoring the infant's medical needs.

The progress notes showed the BM tested positive for opiates in January 2018 and as a result, ACS increased monitoring of the BM's drug treatment program. Regarding the risk assessment, ACS observed the BM appeared to be overwhelmed. The home was disorganized and the sleeping arrangements were inadequate. The BM and BF did not always make themselves available for services. ACS provided casework counseling, furniture, and supplies to address the identified needs. ACS completed the required number of casework contacts to meet the program requirements.

On 4/11/18, the preventive services case was open when ACS received notification of the infant's death.

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