Child Fatality Report

Report Identification Number: NY-19-028

Prepared by: New York City Regional Office

Issue Date: Sep 24, 2019

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 03/25/2019
Initial Date OCFS Notified: 03/25/2019

Presenting Information

The SCR registered three reports on 3/25/19 regarding the death of the SC who was in the care of the uncle overnight. The report alleged the SC slept on the same bed with the uncle who found the SC unresponsive on the bed, and called 911. The report stated EMS arrived at the scene and transported the SC to the hospital where he was pronounced dead. The report also stated the mother had taken the SC to the hospital over the weekend because he had exhibited symptoms of a cold. The SC was sent home without a prescription; however, the mother began to give him over the counter medications and instructed the uncle to continue to administer the same while the SC was in his care.

Executive Summary

The SC was one-month old when he died on 3/25/19. As of the wring of this report, the ME had not issued an autopsy report or provided a preliminary cause or manner of death. ACS was awaiting the autopsy report to determine whether the medications or the co-sleeping contributed to the SC's death.

The family had an open investigation dated 2/6/19, due to the SC testing positive for marijuana at the time of his birth. As a result of this report, ACS held an enhanced child safety conference (CSC) and referred the family to the Jewish Board Family and Children Services (JBFCS) on 3/8/19.

On 3/25/19, the SCR registered three reports with allegations of DOA/Fatl and IG of the SC by the parents and a family friend who the SCR referred to as an uncle.

At the time of the fatality, the SC was in the care of the family friend who resided in Brooklyn; the sibling was home with the father, and the mother was at work.

ACS initiated the investigation timely and made relevant collateral contacts with the NYPD, medical staff and the ME. None of the collaterals had any suspicion of foul play or criminality regarding the death of the SC.

ACS documented that according to the parents, the SC was not feeling well when he was left in the friend's care and the mother instructed the friend to give the SC over the counter medications for a cold, and constipation, and to help the SC sleep. The mother did not consult the SC's pediatrician about her decision to use these medications. On 3/25/19, the friend laid the SC to sleep with him on an adult bed and when he awoke the SC was unresponsive. The friend then called 911 and the SC was transported to Kings County Hospital (KCH) where the SC was pronounced dead.

The ME and the NYPD completed a crime scene investigation at the friend's home. ACS attempted to complete a home assessment of the friend's apartment, but was not allowed to do so by the friend or his roommates and the size of the adult bed was not obtained. Information from the friend was consistent with what was reported to the NYPD and ACS.

On 3/25/19, ACS made a visit to the parents' home and although there were no safety concerns present for the surviving sibling, an emergency removal was conducted and the sibling was placed with the PGPs. ACS escorted the PGM with the sibling to the hospital and had the sibling medically cleared. There were no concerns of abuse or neglect reported regarding the parents' ability to care for the sibling.

On 3/26/19, ACS filed an Article 10 Neglect Petition at the Bronx County Family Court (BCFC) for derivative neglect

naming the parents as the respondents on behalf of the sibling. At the initial hearing, the judge ordered the sibling remain in the care of the PGPs with COS. On 4/11/19, the sibling was returned to the parents with continued PPRS and COS.

On 8/28/19, ACS substantiated the allegation of IG against the parents and the friend; however, did not provide individual narratives to support the determination for each of the subjects.

On 8/28/19, ACS unsubstantiated the DOA/FATL allegation against each subject; however, ACS did not provide individual narratives to support the determinations for each of the subjects. ACS based their decision on the fact that they were unable to obtain an autopsy report from the ME.

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?** No
  - **Safety assessment due at the time of determination?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Unable to Determine

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	The safety decision selected noted that the sibling was in immediate or impending danger of serious harm which is consistent with a removal of a child; however the safety factors and supporting comments did not support the safety decision.

Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The safety decision selected noted that the sibling was in immediate or impending danger of serious harm; however, the safety factors and supporting comments did not support the safety decision.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriateness of allegation determination
Summary:	ACS unsubstantiated the allegation of DOA/FATL against all the subjects solely because they did not obtain an autopsy report. ACS substantiated the allegation of IG against all subjects, but did not provide narratives to support the determinations.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	ACS selected a safety decision that reflected there were no safety factors, however, the family was under COS and was also referred for services. The safety assessment did not reflect the circumstances of the case documentation.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Failure to provide notice of report
Summary:	ACS did not issue a Notice of Existence to the friend who was named as a subject of the report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Failure to Provide Notice of Indication
Summary:	ACS failed to provide a Notice of Indication to all the subjects of the report.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/25/2019 **Time of Death:** 12:00 PM

Time of fatal incident, if different than time of death: 12:06 PM

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

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

On 3/25/19, while responding to this report, ACS documented that staff smelled marijuana in the home and it was revealed a MU was smoking in the home. The sibling was in the care of the PGP's and ACS informed the parents of the emergency removal and placement of the sibling with the PGP's. The parents were defensive and there was no focus on gathering

relevant information from the parents regarding their decision to have the SC stay with the friend even though the SC was ill and the friend resided in another county. ACS interviewed the parents several times throughout the investigation; however, it seemed that after ACS' decision to conduct an emergency removal of the sibling ACS was unable to engage the parents in a discussion regarding the events leading to the SC's death. However, ACS made collateral contacts with the NYPD, medical staff and the friend and were able to confirm some relevant information with the parents.

Based on the collateral contacts, ACS was able to ascertain that the parents did not make adequate sleeping arrangements and did not educate the friend on safe sleep practices. Also, the mother gave the friend several over the counter medications without consulting with the SC's pediatrician.

ACS contacted KCH's attending physician and learned on 3/25/19, the SC arrived at the ER at 11:35 A.M. via ambulance and was accompanied by the friend. The SC was unresponsive, had no pulse, and resuscitation efforts failed.

According to hospital staff, the friend reported the SC slept over night at his home on 3/24/19, but had not been feeling well. The friend stated the SC had a cold and a cough, was crying a lot and was having difficulty sleeping; so, he called the mother who directed him to administer the medications she had packed for the SC. The friend said the mother directed him to add the medications to the SC's formula and place the SC to sleep on his abdomen. The friend said when he followed these instructions, the SC fell asleep, and he then covered the SC with a blanket. The friend said he fell asleep on the bed with the SC by his side at about 7:00 A.M, and when he woke up at 11:00 A.M., he found the SC lying next to him unresponsive. The friend said he consulted with his roommates who confirmed the SC was not breathing, and then he called 911.

According to the medical records, the PGM took the SC to see the pediatrician on 3/20/19, due to his cold and constipation. The doctor found the SC was well enough to go home, but the SC's cold got progressively worse. The mother said the SC had no fever, but had difficulty sleeping; and her sister suggested a sleep aid for the SC.

The NYPD stated that according to the medical staff at the hospital there was no sign of trauma or roll over. According to the NYPD, they went to the friend's home and the ME took pictures of the death scene, which ACS requested.

Both the PPRS agency and ACS continued to visit the family regularly and there were no concerns about the sibling's safety. The investigation was ongoing and ACS continued to work on gathering information regarding the sleeping arrangements and the ME's report. No determination had been made.

On 8/28/19, ACS substantiated the allegation of the report. The case was indicated and remained open for COS and services.

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: There was no documentation of an MDT investigation; however, the investigation adhered to previously approved protocols for joint investigation.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051021 - Deceased Child, Male, 2 Mons	051476 - Father, Male, 25 Year(s)	DOA / Fatality	Unsubstantiated
051021 - Deceased Child, Male, 2 Mons	051476 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
051021 - Deceased Child, Male, 2 Mons	051473 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
051021 - Deceased Child, Male, 2 Mons	051473 - Father, Male, 25 Year(s)	DOA / Fatality	Unsubstantiated
051021 - Deceased Child, Male, 2 Mons	051022 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
051021 - Deceased Child, Male, 2 Mons	051022 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

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

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: These safety assessments were not completed properly; the selection of the safety decisions and/or safety factors, and the completion of the instrument of each assessment were not consistent with the case circumstances or the information requested in the instrument.				

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
ACS conducted an emergency removal, but neither the safety assessments nor the documentation reflected the sibling was in immediate danger of serious harm. ACS had concerns about the parents drug use, but there was no information to indicate this hindered their ability to properly provide care for the sibling.

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	☐	☐	☐	☐	☐	☒	☐

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 initially conducted a removal of the sibling after the SC's death and filed an Article 10 Neglect Petition in court on behalf of the sibling. The sibling later returned to the home. ACS also provided a child care voucher for daycare services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the

fatality? Yes
Explain:
ACS had referred the parents for PPRS, and after they fatality provided funds for the funeral/burial assistance.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/06/2019	Deceased Child, Male, 1 Days	Father, Male, 25 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 1 Days	Other Adult - Friend, Male, 26 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 1 Days	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 1 Days	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
On 2/6/19, the SCR registered a report alleging that the mother had given birth to the SC and tested positive for marijuana. The report stated the results of the SC's toxicology report were pending.

During this investigation, the SC's toxicology result returned positive. The SC died on 3/25/19 after being ill for several days. However, when the SC was found unresponsive he was in the care of a friend and had been co-sleeping with the friend. It was unknown whether the co-sleeping or over counter medications caused or contributed to his death.

Report Determination: Indicated	**Date of Determination:** 08/28/2019

Basis for Determination:
ACS substantiated the allegation of IG against the parents and the friend. ACS did not provide a clear and concise basis for the determination narrative for the parents. Instead, ACS documented a summary of the investigation.

ACS unsubstantiated the allegation of PD/AM of the SC by the mother because at the time of the SC's birth she had provisions for the SC. Also, ACS cited there was no evidence to suggest her drug use impacted her ability to care for the SC.

ACS substantiated the allegation of IG of the SC against the friend, but did not provide a determination narrative to support this decision.

OCFS Review Results:
ACS initiated a timely investigation and provided the parents with safe sleep information. There were no safety concerns regarding the condition of the home, and the parents had appropriate sleeping arrangements, and provisions for the children. The children were checked at each visit and they had no marks or bruises. ACS had strong concerns about the parents' drug use, but they were unable to articulate how this impacted their ability to care for the children. Based on this concern, on 3/8/19, ACS held a CSC and referred the family for PPRS. On 3/26/19, ACS filed an Article 10 Neglect Petition on behalf of the sibling and was granted COS for the family with ongoing PPRS.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
ACS selected safety factors that were not supported by case documentation. In addition, the comments to support the safety factors selected consisted of the parents' drug use with no clear documentation to support how it impacted negatively their ability to care for the children.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Pre-Determination/Supervisor Review

Summary:
Supervisory reviews and directives were not thorough, safety assessments and the investigation conclusion were approved even though the documentation was not consistent or relevant to the case circumstances. There were lapses in the casework documentation activity progress notes.

Legal Reference:
18 NYCRR 432.2(b)(3)(v)

Action:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Adequacy of Progress Notes

Summary:

There was no consistency in the progress notes. ACS stopped documentation on 4/5/19, although they continued to have contact with the family to address the death of the SC.

Legal Reference:

18 NYCRR 428.5

Action:

ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Appropriateness of allegation determination

Summary:

ACS appropriately substantiated the allegation of IG against all subjects, but did not provide supportive determination narratives for each of the subjects. No determination narrative was provided for the friend who ACS added to the report. ACS unsubstantiated the allegation of PD/AM against the mother; however, this issue was brought up as a safety factor through out the investigation.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

ACS selected safety decision that reflected there were no safety factors even though the family was under COS and referred for services.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Failure to Provide Notice of Indication

Summary:

ACS did not issue the Notice of Indication to the subjects of the report.

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

Action:

ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Failure to provide notice of report

Summary:

ACS did not issue a Notice of Existence to the friend who ACS added as a subject of the report.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

The parents had no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

The parents had no known CPS history outside 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: 03/08/2019

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☐	☐	☒	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☐	☒	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☐	☐	☒	☐

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:
The family was under investigation when they were referred by ACS to PPRS. When the SC died on 3/25/19, ACS filed an Article 10 Petition on 3/26/19 and was granted COS.

Preventive Services History

The family was referred by ACS to the JBCFS' PPRS' enhanced program on 3/8/19. The referral was made as a result of a CSC dated 3/8/19. This is a pilot program in the Bronx where ACS refers families to expedite services after a CSC. The referral to this program was primarily due to the parents' use of marijuana and the mother's and the SC's positive toxicology for marijuana at the time of the SC's birth.

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