Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-20-055

Prepared by: New York City Regional Office

Issue Date: Dec 20, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 06/20/2020
Initial Date OCFS Notified: 06/20/2020

Presenting Information

On 6/20/20, the SCR registered a report stating that the two-year-old subject child and his 6-month-old sibling were in the care of the mother's partner who reported the subject child was running around in the home when he suddenly collapsed. The report stated the mother returned from the laundromat with the four-year-old sibling, and found the subject child unresponsive. The subject child was transported to the hospital where he was pronounced dead at 4:00 P.M. The report stated the subject child was healthy, and the mother's paramour did not provide a plausible information for the subject child's death.

Additional information noted on 6/20/2020 the mother left the home at 11:00 A.M. with the four-year-old child and left her paramour with the subject child and the 6-month-old sibling. The information alleged at approximately 1:45 P.M., the subject child began to cry. The paramour gave him juice, and the child then went to his bedroom. The mother arrived about 15 minutes later and found the subject child in his bedroom unconscious and foaming at the mouth. The paramour called 911 and the child was transported to the hospital, where he was pronounced dead.

Executive Summary

This one-year-old male child died on 6/20/20. The Medical Examiner listed the cause of death as blunt force trauma of the torso and the manner of death as homicide.

On 6/20/20, the SCR registered a report stating that the 2 yo SC and his 6-month-old sibling were in the care of the mother's partner (father of 6-month-old infant). The mother was not in the home at the time of the incident. When she returned home she saw the child in bed and thought he was sleeping. She attempted to awaken the child but he did not respond. The mother called 911 for emergency medical assistance. EMS attempted resuscitation; however, the child could not be revived; he was later pronounced dead at the hospital at 3:00 P.M on 6/20/20. The SCR received additional information on 6/20/2020 stating the mother left the home at 11:00 A.M. and left the PS with the SC and the 6-month old sibling. At approximately 1:45 P.M., the SC began to cry, the PS gave him juice, and the SC then went to his bedroom. The mother arrived about 15 minutes later and found the SC in his bedroom unconscious and foaming at the mouth. The PS called 911 and the SC was transported to the hospital, where he was pronounced dead at 3:03 P.M.

ACS maintained contact with the NYPD, medical staff, and family members, and the DA's office. The NYPD determined the SC's death has been determined to be a homicide. The ME confirmed the child's death was a homicide and detailed the extent of the child's injuries which included broken ribs, lacerations to the organs, and internal bleeding. The NYPD recommended the removal of the siblings and that the parents be denied any contact with the siblings until the criminal investigation was completed.

ACS held a conference with the agency's Family Court Legal Services to seek a remand of the surviving sibling, and on 6/22/20, ACS filed an Article 10 Abuse Petition for the sibling in the Kings County Family Court. The remand was granted. Both parents obtained legal counsel, and neither had been arrested.

ACS observed the surviving siblings, two of whom were already residing with maternal relatives and all were free of marks and bruises. There were no safety concerns noted for the children who were with the maternal relatives.

On 10/9/20, ACS substantiated the allegations of the report against the mother and her partner. The case remains open as

the surviving sibling who had been residing with the mother and her partner was placed in foster care. ACS documented initially the mother was making the supervised visits but as the months progressed, the mother made only sporadic visits.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
The decision to close the investigation was appropriate and was based on information obtained during the course of the investigation.

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 level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion was commensurate with the case circumstances. Additionally, there was documentation of supervisory consultation during the investigation.

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

Child Fatality Report

Date of Death: 06/20/2020 **Time of Death:** 03:03 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? Yes
At time of incident supervisor was: Unknown if they were 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	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	6 Month(s)
Other Household 1	Sibling	No Role	Female	11 Year(s)
Other Household 2	Sibling	No Role	Female	5 Year(s)

LDSS Response

ACS initiated the investigation of this fatality report in a timely manner. Contact was made with law enforcement, the ME and family members.

On 6/20/20 ACS conducted an assessment of the surviving sibling and made the decision to place the sibling in kinship foster care based on the circumstances of the one-year-old child's death.

On 6/22/20, the ME explained that the child's death was a homicide and the cause of death was blunt force trauma to the torso. The findings indicated that the child had a right rib fracture to the costeral (back side) and small rib fracture on the left side. The ME also noted the right rib fracture was the most important fracture as the rib was displaced. The ME further indicated the child had a laceration to the liver and kidney, a tear in the mesentary tissue, and had blood in his abdomen at the time of the autopsy. The ME further noted the injury happened on the day of the child's death but could not provide a

more definitive time frame for when the injury occurred. The ME further noted an old splash-burn mark to the child's cheek. It was noted that the incident in which the child had sustained the burn had been investigated by ACS. The ME confirmed the child had been assaulted.

Between 6/29/20-8/26/20 ACS made contact with EMS and learned that the adult female whom they believed may have been the mother called 911 but did not have a sense of urgency about the child's condition. EMS crew said this female did not want to be involved at all and she waited downstairs while the crew responded to the unresponsive child upstairs. She was also not crying or emotional. When crew asked who she was, she declined to answer. EMS staff also reported there was a male at the location; however, the crew did not establish his identity except to verify that he was not the father of the child. The adult male was performing CPR on the child on the living room floor when the crew arrived. It was unknown if the child was moved from another location before CPR was initiated. Both adults on the premises refused to give personal information. The adult female was downstairs speaking on the phone with another male, who the crew believed to be the father. She was telling him that he needed to get there right now and she would pay for the cab. She also mentioned an ACS case to the male on the phone.

According to the EMS crew, the adult female said she was in the laundry room and saw the toddler awake an hour before. The adult male present on scene told the BLS (Basic Life Support) crew that the child was in the room crying and then became silent. According to the adult male this was approximately 20 minutes before 911 was called. The male stated that when mother leaves the apartment, the child always throws a tantrum and gets placed in the bedroom until he is calm. The EMS crew said neither adult appeared to be under the influence and unknown if either has a clinical history. The adult female accompanied the child to Coney Island Hospital while the adult male stayed at the residence. There were no visible signs of injury. The child was pronounced dead in the hospital's ER.

Law enforcement officers responded to the residence as well. They reported there were no safety hazards noted in the home, the child appeared to be well groomed and both adults said the child had no complaints prior to the incident. It was unknown how the adult female was notified of the child’s condition, or when the child had been placed in the other room for his tantrum and how long he had been left in the room. Later on 9/4/20, CPS received a call from the NYPD detective who reported that no arrests had been made in connection with the death of the child. ACS contacted the DA's office and was informed that until more concrete evidence was found no arrests would be made. Law enforcement also indicated the mother was not cooperating with the criminal investigation and had provided varying accounts.

On 9/8/20, the ME noted the death certificate had been completed. The cause of death was listed as blunt force trauma to the torso, and the manner of death was Homicide. The ME noted that the child also had other fractures in different stages of healing and suggested the fractures had occurred within 4-5 months of the child's death.

The CPS interviewed the mother who said she was not in the home at the time the incident occured as she had left for the laundromat. When she returned, the one-year-old child was in bed and appeared to be sleeping. The mother said when she attempted to wake him, he did not respond. The mother said she called 911 and both EMS and the police responded. The mother did not provide any explanations regarding the child's injuries. Both the mother and her paramour denied hurting the child.

The child's father was also interviewed but he did not reside in the home and had no information regarding the death of the child.

On 10/9/2020, ACS substantiated the allegations of the report against both adults in the home and indicated the report. ACS substantiated the allegations on the basis that there was credible evidence that the adults inflicted or allowed to be inflicted physical injuries to the child other than by accidental means. To support this decision ACS cited the ME's report which detailed the child's injuries plus the fact that the injuries were inflicted on the day of the child's death. The mother and her partner were the only ones caring for the children at the time the child was injured and subsequently died.

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: Case documentation reflected an MDT response.

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
054382 - Deceased Child, Male, 1 Yrs	055945 - Mother's Partner, Male, 21 Year(s)	DOA / Fatality	Substantiated
054382 - Deceased Child, Male, 1 Yrs	055945 - Mother's Partner, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
055942 - Sibling, Female, 6 Month(s)	055941 - Mother, Female, 27 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?	☒	☐	☐	☐
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?	☒	☐	☐	☐

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:
ACS assessed that foster care placement of the surviving sibling was needed. The child was placed. The mother was offered services.

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 assessed the surviving sibling was in immediate danger of serious harm given the circumstances of the death of the child. The sibling was removed and placed in kinship foster care with the paternal grandmother.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/22/2020	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	055941 Mother Female 27 Year(s)	
Comments:		

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:
The surviving sibling was referred for grief counseling through play therapy.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Mother was referred for grief counseling. Alleged subject was arrested and taken into custody.

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? Yes
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/09/2019	Sibling, Female, 1 Days	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes

Report Summary:
On 12/9/19, the SCR registered a report based on the mother testing positive after she gave birth to her youngest child on 12/8/2019. The mother reported that she smoked marijuana to gain an appetite. The result of the newborn's toxicology was pending. The father of the newborn is the subject of the fatality report. The allegation of this report was PD/AM against the mother.

Report Determination: Indicated | **Date of Determination:** 02/06/2020

Basis for Determination:
ACS substantiated the allegation on the basis of some credible evidence to support the allegation. The mother admitted to smoking marijuana two weeks prior to the birth of the child. ACS also cited prior history of marijuana use to support their findings.

ACS' decision to substantiate was based on the pre-birth activity of the mother.

OCFS Review Results:
The documentation of the overall investigation was not thorough, clear and concise. ACS learned the now deceased

child, was also in the hospital with the mother as the mother indicated she did not have childcare and, did not want to leave him with the father of the surviving sibling because the one year old was not his child. Also, it was reported the mother was observed hitting the one-year-old child when he cried. This concern was not adequately investigated or followed up on. The investigation focus shifted to BM's marijuana use.

Supervisory directives did not seem to focus on ongoing assessments during the investigation. This was also evident for approvals of the safety assessments that were not completed properly. The plan for the determination safety assessment did not include specific information as to how it would protect the children, did not include a monitoring role and/or date.

The documentation of the 7-day safety assessment was not clear and concise. Additionally, on 2/6/20, ACS completed a determination safety assessment and selected safety decision 3, however, did not include safety factor #1 as it related to prior history. ACS listed the mother's positive toxicology results but did not document how her drug use impacted her ability to care, protect, provide and/or supervise the children.

A Child Safety Conference (CSC) was held on 12/24/19; and the BM attended via telephone. The recommended safety intervention was: "file a neglect petition against the BM to mandate she participate in services that included: Domestic violence counseling, parenting skills, and mental health evaluation." An Article X petition was filed in family court by CPS on 12/26/19; the children were released to the BM with Court Ordered Supervision (COS). On the same date, the BM signed the initial FASP and was provided with a copy of the service plan. The completed a safety plan was not detailed.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The documentation of the 7-day safety assessment was not clear and concise. Additionally, on 2/6/20, ACS completed a determination safety assessment and selected safety decision 3, however, did not include safety factor #1 as it related to prior history. ACS listed the mother's positive toxicology results but did not document how her drug use impacted on her ability to care, protect, provide and/or supervise the children. ACS completed a safety plan that was not detailed.

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

Action:
ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The documentation of the overall investigation was not clear and concise. Supervisory directives did not seem to focus on ongoing assessments during the investigation. This was also evident on approvals of the safety assessments that were not completed properly. The plan for the determination safety assessment did not include specific information as to how it would protect the children fully or partially and did not include a monitoring role and/or date.

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

Action:
ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.

[redacted]

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

Prior to the most recent CPS investigation that led to the current/open FSS in CONNECTIONS, the BM had two biological children who were removed from her care.

On 12/1/09, the case was indicated against the mother and the father of the then subject child for IG. The parents were unable to provide the child with the basic needs. A neglect petition was filed against the parents as they failed to visit the child in the hospital, they did not secure medical insurance for the child, and they did not try to understand the child's medical needs. The child was removed from the parents and ultimately the MGM obtained custody of the child in 2010.

On 9/19/13, the case was indicated for IG against the mother and the family member as the mother, knowingly, allowed the family member who had severe mental health issues to care for the child. The family member stabbed a neighbor in the presence of the now 11-year-old child. The case was indicated against the mother because she allowed the child to spend time with the family member despite the child not spending time with the family member in three years.

BM had another child, and in 2015, an Article Ten petition was filed in Manhattan Family Court following allegations of Domestic Violence (BM was the aggressor and has history of DV as both perpetrator and victim), PD/AM and IG; the child was released to the BM with Court Ordered Supervision by CPS. The service plan included domestic violence counseling; parenting skills training; mental health evaluation.

The BM did not comply with service plan and on 6/7/16, the SCR registered a report with allegations of PD/AM, LS, and IG of the subject child. The case was indicated against the mother and the father of the then subject child for LS, IG, and PD/AM. The parents left the shelter unit to argue in the hallway. The mother attacked the father while he was holding the child in his arms. The parents admitted to smoking marijuana.

An Article 10 Petition was filed, the child was remanded and removed from the parents' care on 9/26/2016. The child was released to her godmother while an interstate compact was completed for the MGM who resided in South Carolina. Custody of this child was granted to the MGM in 2018.

Known CPS History Outside of NYS

There was 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: 02/25/2020

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 02/25/2020

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?	☒	☐	☐	☐
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 were provided through a local provider agency. The mother signed for services on 2/25/20.

Required Action(s)

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

Issue:	Adequacy of Preventive Services casework contacts
Summary:	There was no documentation that the BF was assessed, engaged in service planning, or asked if he had any concerns for his child's well-being. CP did not inquire of the BM if this contact with the BF was a new event, if she had concerns for her child while in BF's care, if he was a support system now that she had a new child, if conflicts were present with her and the fathers of her other children.
Legal Reference:	18 NYCRR 423.4(c)(1)(ii)(d)
Action:	ACS must obtain a performance improvement plan from the provider agency and submit within 45 days the plan that identifies what action the agency has, or will take, to address the citation(s) 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 will attend and what was discussed.

Preventive Services History

An FSS stage was opened on 12/13/19 and on 1/21/20, a call was placed to the SCR because the now deceased child was taken to the hospital with burns on his face; the information was accepted as an ADD INFO. Per the BM and youngest child's father, the father was cooking and did not realize the child had entered the kitchen. The child was reportedly burned by oil in the frying pan. CPS spoke with the BM, youngest child's father, and hospital staff to discuss how the child was burned. The hospital staff indicated that the burns were consistent with the parents' reports. However, no discussion regarding the parents' relationship, the frequency of the father's supervision of the child, his ability to effectively care for/supervise the child, or the relationship between the child and father was documented.

In February 2020, the family was referred for preventive services (PPRS) FTR program. A joint home visit was conducted on 2/10/20 by CPS, the provider agency Case Planner (CP), and the family. The service plan was discussed. The BM signed for PPRS services on 2/25/20. The discussed service plan included parenting skills, substance abuse treatment, domestic violence counseling, mental health evaluation, and early intervention assessment/evaluation for both children, in addition to drug screening for the mother. The BM was not in agreement with drug screening, and indicated she would confer with her attorney.

In the initial stage of the services case, the family was not available for scheduled or unscheduled home visits with the CP. ACS's FSU conducted a home visit on 3/17/20, but due to concerns regarding COVID-19 the provider agency's CP did not attend. The CP contacted the CPS to discuss the outcome of the meeting; there is clear evidence in the record of CP and CPS maintaining contact throughout the services case.

Subsequent to the 3/17/20 meeting, the BM made herself and the children available for facetime visits with the CP. The CP observed the children in the home on the facetime calls; minimal contact occurred with the father of the younger child. He was also not identified as the secondary caretaker on the Initial or Comprehensive FASPs completed on 2/3/20 and 3/25/20 respectively; therefore the assessments in the FASP were incomplete and inaccurate. The initial FASP had a RAP risk rating of very high and in the Comprehensive FASP report date 3/25/20, the risk rating was deemed moderate. It is unclear

what underpinned the agency's decision to reassess and lower the risk to the children in the home particularly since they had had minimal contact with the family by the 3/25/20 report date. The fact that ACS's FSU was involved may have led the provider agency to believe that video contact with the family was sufficient.

The children were observed during the virtual facetime visits conducted by the provider agency; however, it was noted that at times the now deceased child was staying with his father or other relatives. This information was not fully explored. The CP observed the child in the father's home (via video) after receiving the father's contact information; however, there was no documentation that the father was assessed or was engaged in service planning.

On 6/8/20, the mother contacted the CP to seek advice after a conflict with the surviving sibling's father who wanted to take the child out of state for a month and possibly, permanently. The mother was not amenable to this arrangement. The CP informed the mother of the terms of the COS and urged the mother to speak with her attorney.

The CP attempted to contact the BM via facetime 6/18/20 and 6/19/20, and when unable to reach her sent text messages. The BM replied both times saying that she missed the call or had attempted to contact CP.

The case documentation reflected referrals for some services; however, not all service needs were addressed.

On 6/20/20, the SCR registered a report of the death of the one-year-old male child.

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