NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-14-079 **Prepared by: New York City Regional Office**

Issue Date: 1/2/2015

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 OC = Other Child MGM/PGM = Maternal/parental Grandmother	SM = Subject Mother BF = Biological Father FM = Foster Mother MGF/PGF = Maternal/parental Grandfather	SC = Subject Child SF = Surviving Father FF = Foster father DCP = Day Care Provider
Contacts LE = Law Enforcement EMS = Emergency Medical Services DC = Day Care	CW = Caseworker Dr = Doctor CPR = Cardiopulmonary Resuscitation	CP = CasePlanner ME = Medical Examier FD = Fire Department
Allegations L/B/W = Lacerations/Bruises /Welts B/S = Burns / Scalding PD/AM = Parent's Drug Alcohol Misuse M/FTTH= Malnutrition/Failure--to-Thrive LS = Lack of Supervision OTH/COI = Other	FX = Fractures S/D/S = Swelling/Dislocation /Sprains CD/A = Child's Drug/Alcohol Use P/Nx = Poisoning/ Noxious Substance IF/C/S = Inadequate Food/Clothing /Shelter Ab = Abandonment	II = Internal Injuries C/T/S = Choking/Twisting /Shaking MN = Medical Neglect XCP = Excessive Corporal Punishment IG = Inadequate Guardianship SO = Sex Offender
Miscellaneous LDSS = Local Department of Social Service	IND = Indicated ACS = Administration for Children's Services	UNF = Unfounded NYPD = New York City Police Department

Case Information

Report Type: Child Deceased **Jurisdiction:** Bronx **Date of Death:** 07/02/2014

Age: 11 year(s) **Gender:** Male **Initial Date OCFS Notified:** 07/07/2014

Presenting Information

On 7/7/14, the SCR registered a report noting that the eleven-year-old SC had Type 1 diabetes and was supposed to check his glucose levels three times a day and administer insulin. The report noted that the mother's failure to provide adequate medical care for the SC's diabetes caused his death. The report stated that on 6/30/14, the SC was brought to the hospital in critical condition and his glucose levels were extremely high. The SC was admitted to the hospital and pronounced brain dead on 7/2/14 @ 2:19 P.M. The child remained on a ventilator until 7/14/14 when he was removed from the support.

Executive Summary

The eleven-year old SC died on 7/2/14 at 2:19 P.M. The autopsy report is pending. This was the mother's only child.

In August 2013, the SC was diagnosed with Type I diabetes. The mother was not certain she could care for the SC's medical needs and arranged for him to live with his father. Although the parents had a long history of domestic violence (DV), their relationship had improved. During the time the SC resided with the father, the stepmother took an active role in the child's medical care and school supervision as the father worked full time. The father filed a custody petition for the SC; however, the case was dismissed without prejudice. The SC returned to live with his mother in November 2013.

On 6/29/14, the SC's blood sugar level was high and the mother did not administer the prescribed insulin. The child went into a diabetic coma and was taken to Lincoln Hospital. On the same day, the SC was transferred to Montefiore Hospital where he was admitted and later died.

On 7/7/14, the SCR registered a report pertaining to the SC's death. ACS' investigation revealed that the SC's daily blood sugar levels had been high for two consecutive weeks prior to the incident that led to his hospitalization and subsequent death.

On 9/26/14, ACS appropriately indicated the report against the mother for DOA. ACS also substantiated the allegation of Lack of Medical Care as the mother had failed to provide the child with the appropriate medication in the weeks prior to his death. ACS determined that this was medical neglect and it directly contributed to the child's death.

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?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the** Yes, sufficient information was gathered to determine all

investigation?	allegations.
• **Was the determination made by the district to unfound or indicate appropriate?**	Yes

Explain:
N/A

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

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	ACS did not provide the father with a Notice of Existence 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 and inform NYCRO of the date of the meeting, who attended, and what was discussed. ACS must also submit a corrective action 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: 07/02/2014 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

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

Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	11 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)

LDSS Response

On 6/29/14, the child had been complaining that he did not feel well yet the mother allowed him to go swimming without properly administering his medication. The child's blood sugar was above 500 and 911 was contacted as he went into diabetic coma. EMS transported the child to the hospital where he was admitted. The child was connected to a ventilator.

ACS maintained contact with the medical staff attending to the SC at Montefiore Hospital where he was pronounced dead on 7/2/14 and it was confirmed that the SC was not monitoring his blood sugar levels nor administering his insulin as instructed. ACS determined that the mother allowed the SC to assume the responsibility for monitoring his medical condition and provided the supervision.

The ME has not issued the autopsy report nor provided a verbal report for the official cause and manner of death. The case was referred to the District Attorney's (DA) Office. As of 12/4/14, the NYPD and the DA's Office have open investigations pending the autopsy report.

ACS completed their investigation within the required timeframe base on the medical information obtain which clearly indicated that the mother's negligence of the child's medical condition either contributed to or directly cause the SC's death.

ACS appropriately substantiated the allegations of the report.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: From a medical cause

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: N/A

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
Deceased Child Male 11 Year(s)	Mother Female 33 Year(s)	Lack of Medical Care	Substantiated
Deceased Child Male 11 Year(s)	Mother Female 33 Year(s)	DOA / Fatality	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?	☐	☐	☒	☐
The SCR Report source contacted?	☐	☐	☒	☐
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?	☐	☒	☐	☐

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	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The deceased was the mother's only child.

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? N/A
Explain:
There were no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no other children in the home.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? 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? N/A
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/15/2012	141-Deceased Child,Male, 9 Years	142-Mother,Female, 32 Years	Inadequate Guardianship	Indicated	Yes
	141-Deceased Child,Male, 9 Years	143-Grandparent,Male, 56 Years	Inadequate Guardianship	Indicated	

Report Summary:
The report noted that the MGF was a SO and the mother allowed him to care for the SC. At the time of the report, the mother was hospitalized. A friend was in the home to care for the SC, but did not provide information for a clearance. ACS took no action to address this issue.

The SC reported that he usually visited the MGF with his mother and that he stayed alone with the MGF in 2011 when the mother was in the hospital. The SC was not able to differentiate between a "good touch" and a "bad touch". No referral was made to the Child Advocacy Center.

The mother gave no contact information for the MGF and denied the allegations of the report. ACS did not question the MGF's SO status.

Determination: Unfounded | **Date of Determination:** 01/10/2013

Basis for Determination:
ACS unsubstantiated the allegation of IG against the mother and the MGF noting that there was no credible evidence to

support the allegations of the report. ACS made the determination without interviewing the MGF.

OCFS Review Results:

NYCRO's review revealed that the mother was not cooperative with the investigation. ACS did not make diligent efforts to locate and interview the MGF. The MGF had an indicated case in 2011 for sexually abusing a MU; however, it did not appear that this information was factored into the investigation conducted by ACS at the time.

The SC's school indicated that his promotion was in doubt, but this was not explored.

The SC's doctor was not contacted.

There were no relevant collateral contacts to assess the mother's ability to care for the SC.

ACS did not contact the source of the report to address the concerns noted in the report.

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

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

ACS lacked in making collateral contacts, not following in up with the information provided by the school staff and not properly assissing the safety of the SC.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day and the determination safety assessments were not properly completed. There was insufficient information pertaining to the reported allegations and the family. The friend caring for the child was not cleared by the SCR due to her refusal to provide information. It was not determined whether she resided in the home as stated by the SC.

Legal Reference:

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

Action:

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

Issue:

Review of CPS History

Summary:

The MGF's history was not considered throughout this investigation. The history was relevant to the information provided in the SCR report.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

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

Issue:
Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:
ACS did not utilize the legal definition of abuse and maltreatment when addressing each subject.
Legal Reference:
SSL 412(1) and 412(2)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action 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 did not conduct a thorough investigation; therefore there was not sufficient information to make the determination for the IG allegation as it refers to each subject. The MGF was not seen or interview.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS did not make collateral contacts with the SC's doctor, father, relatives or nieghbors. In addition the information regarding the SC academic issues were not explored further with the school staff, the mother or the SC.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
ACS did not interview the MGF and the documentation did not reflect diligent efforts to contact him.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action 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:
The NOE was not issued to the MGF nor the father (non-custodial parent).
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/16/2013	39-Deceased Child,Male, 10 Years	33-Mother,Female, 34 Years	Inadequate Guardianship	Unfounded	Yes
	39-Deceased Child,Male, 10 Years	34-Aunt/Uncle,Male, 31 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The report alleged that the maternal uncle (MU) would hit the SC and the mother did not intervene. The mother denied the allegations stating that she addressed the issue with the MU and he was no longer visiting her home.

The SC was safe as he was residing with the father due to an arrangement made by the parents. The mother denied the allegations. However, based on the SC's interviews and information he gave to the father the MU would hit him when he was left with the MU. The father filed a custody petition for the SC; however, the case was dismissed without prejudice. The SC returned to live with his mother in November 2013. ACS did not diligently search for the MU for an interview.

Determination: Unfounded | **Date of Determination:** 11/15/2013

Basis for Determination:
ACS unsubstantiated the allegation of IG against the mother citing that she reported that once she learned about the MU hitting the SC she addressed the issue by not allowing him access to the SC. ACS also cited that both the mother and the SC stated that the incident had occurred a long time ago.

ACS unsubstantiated the allegation of IG against the MU without providing a narrative to support their decision or interviewing him.

OCFS Review Results:
Initially, the mother refused to allow ACS to conduct an assessment of her home. The mother indicated that she was relocating to Florida and returning to school. The mother had no interest in caring for the child and noted that she could not care for the SC's medical condition. The mother refused to provide contact information for the MU. There was no continuity with the investigation as information that needed to be re-addressed with the mother was not. Once the SC returned to the mother's care, it appeared that he had a disagreement with his step-brother and felt better being home with the mother. The mother's willingness and/or ability to care for the SC was not assessed.

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

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
ACS did not make significant effort to find the uncle who was listed as the subject of the report. ACS did not use other relatives and/or nieghbor to confirm whether the uncle was living at the mother's home and to obtain a current address.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
ACS must meet with the staff involved in this investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed; and submit a corrective action 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 the reprt for the subjects. However, did not interview or make collateral contact for the MU. There was some credible evidence to indicate this case against the mother. She was sporadic in making decisions for herself and this impacted the SC's stability.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
ACS did not make relevant diligent efforts to contact the MU who was a subject listed in this report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7 day and determination safety assessmentments were completed timely, but the safety decisions ans safety factors selected were not consistent with the case circumstances. Also, the comments did not support the selected safety factors.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to offer services
Summary:
ACS did not assess whether the mother would properly care for the SC. Based on the mother's sporadic decisions, her ability to suddenly commit to care for the SC should have been of concern due to the required medical care. No services were offered monitor her care of the SC.

Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/30/2014	222-Deceased Child,Male, 11 Years	221-Mother,Female, 33 Years	Inadequate Guardianship	Indicated	Yes
	222-Deceased Child,Male, 11 Years	221-Mother,Female, 33 Years	Lack of Medical Care	Indicated	

Report Summary:
On 6/29/14, the SC was not feeling well, but went swimming. When he returned home, he went to sleep. At 4:21 P.M, the SC's sugar level was 500 and was administered insulin. Between 6:30 P.M. and 7:00 P.M., the SC awoke with a headache. The mother gave him Ibuprofen and 20 units of insulin. At 8:30 P.M., the mother's friend arrived and noticed the SC was having difficulty breathing. The SC then stopped breathing and the friend began CPR while the mother called 911.

Following the death of the child, the case was referred to the ADA because the SC's glucometer revealed that he was not administered the prescribed amount of insulin for days prior to the incident.

Determination: Indicated | **Date of Determination:** 08/29/2014

Basis for Determination:
ACS substantiated the allegations of IG and MN citing that the mother left the SC with the responsibility of monitoring his own blood sugar level. The SC's blood sugar levels were high for several consecutive days leading to a severe cerebral edema on 6/30/14. ACS cited that the mother was unaware of the results because she was not monitoring the child's condition.

OCFS Review Results:
The SC expired on 7/2/14 @ 2:19 P.M and this investigation continued simultaneously with the fatality investigation that was reported to the SCR on 7/7/14. NYCRO's review revealed that ACS made appropriate collateral contacts to determine that the mother neglected to monitor the SC's medical treatment and this led to his death. The ME has not issued the autopsy report regarding the death of the child.

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

Issue:
Failure to provide notice of report
Summary:
Notice was not issued for the father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

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

The mother was known as a maltreated child in an indicated report dated 9/22/95. The mother had swelling to the right side of her head and a busted lip. The mother disclosed that the MGF had sexual relations with her from ages 3 - 13 years old; but then recanted. The report was indicated against the MGF for L/B/W.

On 10/25/05, the SCR registered a report for allegations of FX and IG of the SC by the mother. The mother accidentally sat on the SC's arm and sought medical attention. The medical examinations revealed that the mother's account was plausible.

On 12/21/05, ACS unsubstantiated the allegations of IG and FX, but added and substantiated the allegation of PD/AM based on a positive result of a drug screening and the mother's admission of marijuana use.

On 8/28/06, the SCR registered a report for IG alleging there was DV in the home in the presence of the SC. On 1/31/07, ACS unsubstantiated the allegation of IG against the parents. ACS added and substantiated the allegation of PD/AM against the mother based on the positive toxicology of the 10/25/05 report.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Services Open at the Time of the Fatality

Required Action(s)

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

Preventive Services History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity

LDSS: Pertinent Information Related to the Fatality

ACS completed safety assessment and a RAP when there were no surviving siblings to assess.

Recommended Action(s)

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

Action:	OCFS is recommending that ACS Supervisory Team review with the Specialists the CONNECTIONS' Step-by-Step Guide: Training for CPS Workers (rev 3/1/07) page 204, which addresses Safety Assessments, and to review the Safety Assessments submitted for this report. Staff must be reminded that when there are no surviving siblings and/or minor children in the home, the Specialist must select "no surviving siblings" in the Investigation Conclusion window of the CONNECTIONS database at the inception of the investigation to prevent the CONNECTIONS system from generating the Safety Assessments and Risk Assessment Profile.

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