NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-091 **Prepared by: New York City Regional Office**

Issue Date: 4/8/2016

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
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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 11/13/2015
Initial Date OCFS Notified: 11/13/2015

Presenting Information

On 11/13/15, the SCR registered a report noting that the SC was diagnosed with a medical condition and was being fed through a feeding tube. The report stated that the SC had been placed in hospice care where he was well cared for and comfortable.

It was alleged that the parents removed the SC from hospice care, uprooted the family from their home in New Jersey, and went to the grandmother's home in the Bronx. It was also alleged that the parents drastically reduced the SC's feeding regimen knowing that this could be harmful to the SC. The report further alleged that because of the parents' actions, the SC died on 11/13/15.

The report noted that the grandmother's home, where the parents took the SC and the sibling to stay, was in a deplorable condition. It was cluttered with household recyclable items including cans, bottles and containers which blocked exits in case of emergency. In addition, there were two other children residing in the home.

Executive Summary

The report concerns the death of a medically fragile child who was visiting his PGM at the time he died. The family objected to an autopsy as the SC had been receiving hospice care and his death was imminent. The ME's report of external examination noted the SC died due to his medical condition and listed the manner of death as natural.

The SC and his family were residents of New Jersey and the SC was a patient at the Hunterdon Hospice. The SC had been hospitalized in July 2015 due to the worsening of his condition and doctors recommended palliative care. The medical staff from the Hunterdon Hospice authorized the parents to travel with the SC to New York to be with extended relatives. The family was linked with the Metropolitan Hospice in New York to receive services as needed. The family was scheduled to stay at the PGM's home in the Bronx from 11/10/15 through 11/23/15.

At the time of the family's visit to New York, the PGM had an open investigation dated 10/2/15 listing her as the subject and the 5-months-old, 13-year-old, and 14-year-old PCs and 16-year-old PU as alleged maltreated children. The allegations of this report were LBW and IG of the children. ACS added the allegation of LMED of the 13, 14 and 16 -year-old children.

On 11/13/15, a report was registered with the SCR concerning the death of the SC. The allegations of the report were DOA fatality, IFCS and IG. The parents were listed as subjects for the DOA allegation of the SC. The parents, PGM and two uncles were listed as subjects for the allegation of IFCS and IG of the SC, sibling, a 5-month-old PC, 16-year-old PU. The 13 and 14-year-old PCs had no role in the fatality report.

According to the family, on 11/13/15 while the PGM was holding the SC, she noticed he was pale and had stopped breathing. The PGM called out to the father and they realized the SC was dead. The parents contacted the Metropolitan Hospice; a registered nurse visited the home and pronounced the SC dead at 8:45 P.M. Due to the SC medical condition and anticipated death, EMS was not called to the scene. The SC was transported to a designated

funeral home. However, after a report was registered with the SCR, the OCME requested that the body be taken to the morgue for the external examination.

ACS made contacts with service providers in NJ concerning the SC and his sibling and there were no concerns about the level of care the parents provided for their children. ACS confirmed that the SC's feeding regimen had changed prior to the discharge from the Hunterdon Hospice. There was no indiscretion reported concerning the parents' feeding regimen for the SC. The NJ DYFS was involved with the family for services.

ACS visited the PGM's home and made contacts with the surviving children who resided with the PGM and two adult uncles. ACS assessed that the surviving children in the PGM's home were safe. The visit to the PGM's also revealed there was adequate provisions and appropriate sleeping accommodations for all the children. However, there were concerns about the 13- and 14-year-old PCs' and 16-year-old PU's educational and developmental needs. ACS explored these concerns and on 12/7/15, ACS indicated the 10/2/15 report for allegations of IG and LMED of the 13 and 14-year-old PCs and the 16-year-old PU by the PGM. The PGM was referred to PPRS and the Kennedy Center to address the children's needs and the concerns regarding the teen children.

On 1/13/16, ACS unfounded the allegations of the 11/13/15 fatality report concerning the SC and all the surviving children against the subjects. ACS determined that the SC died of natural causes and each of the primary caretakers had been meeting the children's basic needs. ACS determined that the SC's parents were not persons legally responsible (PLR) for the children in the PGM's home and the PGM and two PUs were not legally responsible for the SC and the surviving sibling.

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?** 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?** Yes, sufficient information was gathered to determine all 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:	Timely/Adequate 24 Hour Assessment
Summary:	ACS documented a safety decision noting there were safety factors that did not rise to the level of immediate or impending danger of serious harm; however, there were no safety factors. A modification was completed, but the decision remained the same
Legal Reference:	SSL 424(6);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:	Face-to-Face Interview (Subject/Family)
Summary:	ACS did not interview the PUs who were listed as subjects of the report, one of whom was the father of the 5-month-old child was listed as an alleged maltreated child in the 10/2/15 and 11/13/15 investigations.
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:	Overall Completeness and Adequacy of Investigation
Summary:	ACS did not address each allegation as it relates to each of the subjects pertaining to alleged maltreated children. Specifically in the case of the 5-month-old child and her father.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/13/2015 **Time of Death:** 08:48 PM

Time of fatal incident, if different than time of death: 08:45 PM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

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: Not impaired.

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	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	15 Month(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Male	26 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Male	29 Year(s)
Other Household 1	Aunt/Uncle	Alleged Victim	Male	16 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	54 Year(s)
Other Household 1	Other Child	No Role	Male	13 Year(s)
Other Household 1	Other Child	No Role	Male	14 Year(s)
Other Household 1	Other Child	Alleged Victim	Female	5 Month(s)

LDSS Response

Following the receipt of the fatality report, ACS began to investigate both reports together; however, ACS did not properly document relevant information pertaining to the children in the PGM's home in the fatality investigation.

ACS made contact with the SC child's medical providers and learned that the parents were authorized to travel to NY with the SC and that they had previously traveled to NY with the coordination of the hospice services. Additionally, the parents and the PGM had received training on the care of the SC. All medical providers indicated that the parents worked diligently in following instructions and attended all the recommended trainings.

ACS contacted other service providers in NJ and learned that there were no concerns about the care the children received from the parents. The parents had disabilities; however, they were able to change, feed, and administer medication to the SC. The BM received housekeeping services daily and the SC received in home nursing services 7 days a week.

According to the PGM, at the time of the incident, the SC was laying on the chaise lounger. The PGM said she picked up the SC from the chaise and administered his nebulizer treatment/medication then cleaned his mouth with swabs. The PGM noted the SC appeared fine and she began to sing to him. The SC was moving a little and she saw that he opened his eyes and smiled. At one point, the SC gave a brief sigh and closed his eyes; the PGM said this was not unusual. The PGM said she gave the SC a kiss on the forehead and began to place him back on the chaise when she noticed he was not moving. The PGM called the father and they noticed the SC had passed. The PGM was not asked to provide a time line for the events leading to the SC's death. The PGM stated the BF checked the SC's pulse and then called the hospice in NY. A nurse came to the home and pronounced the SC dead at around 8:45 P.M.

The PGM said the surviving children were in the living room, but were unaware of what had occurred. The parents were distraught and did not provide additional details of events leading to the SC's death. There was no effort to interview the SC's uncles listed in the report, one of whom was the father of the 5-month-old infant.

The father of the SC indicated the SC's feeding was reduced while the SC was in care at the hospice in NJ; however, the SC was fed every three hours as instructed. The father indicated that he and the BM were authorized by the hospice to travel to NY and were transported by one of the PUs. The father indicated that they were expecting the SC's death, but were not given a timeframe.

ACS assessed the surviving children had appropriate sleeping arrangements; however, the SC had slept on the chaise. ACS found no hazardous conditions in the home and noted there were adequate provisions for all the children.

The NYPD found no criminality surrounding the SC's death; therefore, no arrests were made.

On 11/18/15, ACS contacted the ME who noted that the SC appeared to have died of natural causes and there was no need to perform an autopsy.

As per ACS' policy, an ICSC was held; however, there was no relevant discussion concerning any safety concerns for the surviving sibling or other children in the home.

The 10/2/15 investigation revealed there were serious concerns about the 13, 14, and 16-year-old children who resided with the PGM; however, this information was not included in the 11/13/15 investigation where the 16-year-old PU was listed as alleged maltreated child. The concerns for these children revolved around their educational and developmental needs. Information about the 5-month -old child who was the daughter of one of the PUs was also not documented in the fatality report.

The 10/2/15 report was appropriately indicated against the PGM for the 13, 14 and 16 year old children.

ACS unfounded the allegations of the report registered on 11/13/15.

Official Manner and Cause of Death

Official Manner: Natural

Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: 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
024662 - Deceased Child, Male, 2 Yrs	024668 - Aunt/Uncle, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024663 - Mother, Female, 33 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024664 - Father, Male, 27 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024666 - Grandparent, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024663 - Mother, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024667 - Aunt/Uncle, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024663 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024667 - Aunt/Uncle, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024664 - Father, Male, 27 Year(s)	DOA / Fatality	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024666 - Grandparent, Female, 54 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024664 - Father, Male, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
024662 - Deceased Child, Male, 2 Yrs	024668 - Aunt/Uncle, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024665 - Sibling, Female, 15 Month(s)	024663 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
024665 - Sibling, Female, 15 Month(s)	024664 - Father, Male, 27	Inadequate Guardianship	Unsubstantiated

	Year(s)		
024665 - Sibling, Female, 15 Month(s)	024667 - Aunt/Uncle, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
024665 - Sibling, Female, 15 Month(s)	024668 - Aunt/Uncle, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
024665 - Sibling, Female, 15 Month(s)	024666 - Grandparent, Female, 54 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024665 - Sibling, Female, 15 Month(s)	024664 - Father, Male, 27 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024665 - Sibling, Female, 15 Month(s)	024663 - Mother, Female, 33 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024665 - Sibling, Female, 15 Month(s)	024668 - Aunt/Uncle, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024665 - Sibling, Female, 15 Month(s)	024667 - Aunt/Uncle, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024665 - Sibling, Female, 15 Month(s)	024666 - Grandparent, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024663 - Mother, Female, 33 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024668 - Aunt/Uncle, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024666 - Grandparent, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024666 - Grandparent, Female, 54 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024663 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024664 - Father, Male, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024664 - Father, Male, 27 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024667 - Aunt/Uncle, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024667 - Aunt/Uncle, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024669 - Other Child - cousin, Female, 5 Month(s)	024668 - Aunt/Uncle, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024670 - Aunt/Uncle, Male, 16 Year(s)	024666 - Grandparent, Female, 54 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024670 - Aunt/Uncle, Male, 16 Year(s)	024667 - Aunt/Uncle, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
024670 - Aunt/Uncle, Male, 16 Year(s)	024666 - Grandparent, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
024670 - Aunt/Uncle, Male, 16 Year(s)	024663 - Mother, Female, 33	Inadequate Food / Clothing /	Unsubstantiated

	Year(s)	Shelter	
024670 - Aunt/Uncle, Male, 16 Year(s)	024663 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
024670 - Aunt/Uncle, Male, 16 Year(s)	024664 - Father, Male, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
024670 - Aunt/Uncle, Male, 16 Year(s)	024664 - Father, Male, 27 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024670 - Aunt/Uncle, Male, 16 Year(s)	024668 - Aunt/Uncle, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
024670 - Aunt/Uncle, Male, 16 Year(s)	024668 - Aunt/Uncle, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
024670 - Aunt/Uncle, Male, 16 Year(s)	024667 - Aunt/Uncle, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated

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?	☒	☐	☐	☐

Additional information:

20 - 23 The children listed on the ORT were not aware of the SC's passing. There was no indication that the PUs were interviewed concerning the death of the SC.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

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 and placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐

Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: N/A				

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 family was receiving services in New Jersey.							

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:
The children did not need immediate services in response to the fatality. Unrelated services would be provided to the sibling by the family's providers in NJ.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The parents returned to NJ and did not have immediate needs in response to the fatality. They were already linked to a hospice service in NJ.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history within three years prior to the fatality.

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

The parents had no known CPS history in NYS. However, in 2013, it was reported to the SCR that the PGM failed to provide food for the 3 subject children (grandchildren). The children were seen rummaging through and eating food they found in garbage cans from the neighborhood and the school's cafeteria. It was also reported that the children did not dress appropriately for the weather. The oldest child had been in the PGM's care since he was ten months old. The other two were in foster care in GA and placed in the PGM's home on 6/1/12. The CW from GA confirmed that the 2 younger children were known to steal, hoard and eat frozen food. The children were neglected by their BM and while in foster care in GA. The report was unfounded.

Known CPS History Outside of NYS

The parents of the SC had no known CPS history outside NYS.

The CPS history involves out of state placements concerning the children of the SC's paternal aunt (PA) who were listed as subject children and part of the household composition in the current fatality report.

In 1999, the 16-year-old MU was born in Va and placed in foster care after he was born with a positive toxicology for illicit drugs. The PGM (his MGM) obtained custody of the MU and subsequently adopted him.

In 2011, the State of Georgia's Department of Human Services requested a home study to consider the PGM as a resource for the now 13-and 14-year-old PCs (of SC of the fatality report) who were in foster care in GA due to lack of housing and educational neglect. They were removed from the PA (their BM) in 2009. ACS opened a FSS from 6/8/11-8/9/11 for an ICPC to consider the PGM (their MGM) as a resource; however, her home was rejected with concerns for the sleeping arrangements, the fact that the PGM did not have her own source of income, and needed to submit relative payment of rent.

A second FSS was open from 2/22/12 –11/1/13 for an ICPC involving the now 13 and 14 year old PCs. On 6/1/12, the PCs were transferred from foster care in GA to NY with ACS supervision. The PGM obtained legal custody of the PCs from on 8/13/13. The PGM declined PPRS at that time.

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 Preventive Services 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 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

Action:	Local policy requires ACS to conduct a CSC when there is a fatality; however, this was not a case that warranted such a conference as there were no safety concerns for the sibling, and therefore there was no discussion concerning safety. Additionally, the family resided in another state and no court intervention in NYS would have been appropriate.

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