NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-011 **Prepared by: New York City Regional Office**

Issue Date: 7/26/2016

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: 9 year(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 01/22/2016
Initial Date OCFS Notified: 01/22/2016

Presenting Information

The OCFS 7065, dated 1/22/16, included information which showed on 12/15/15 the child became ill in school and was taken to the Richmond University Medical Center (RUMC). The RUMC Emergency Room (ER) staff treated the child and then sent him home. The child woke up struggling to breathe at around 3:00 a.m. on 12/16/15 and was taken to the RUMC. He remained in the hospital from 12/16/15 until he was pronounced brain dead 1/22/16, and taken off life support on 1/22/16. The mother was responsible for the child's care at the time.

Executive Summary

This 9-year-old male child died on 1/22/16. NYCRO received written information on 6/14/16 from ACS staff who stated the hospital attending Dr. pronounced the child dead. The Dr. referred the death to the New York ME's office for an autopsy but the referral was not accepted. NYCRO staff contacted the ME's office on 6/15/16 and verified there was no autopsy conducted for this child.

ACS submitted to NYCRO the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive cases. The information regarding the child's death was reported to OCFS under Chapter 485 of the Laws of 2006. At the time of child's death the family had an open child protective services (CPS) case and they had been receiving support services to monitor the child's medical needs. ACS included the information in the open CPS case for further exploration.

According to the ACS case record, with the exception of a medical evaluation which occurred in October, 2014, the parents did not provide records of the child's medical history. ACS was unable to obtain other medical records to evaluate whether the child had a mild or severe pre-existing medical condition, the treatment plan and the parents' ability to manage the child's health needs. ACS found that during 2015, the child had three episodes of illness in school and following each episode, the school contacted the parents who visited the school and followed up with the child's medical treatment. The parents did not provide official procedures and medication to enable the school nurse to treat the child in school.

The child became ill in school on 12/15/15, the nurse contacted the parents and the father visited the school and accompanied the child to the hospital Emergency Room (ER). The attending Dr. gave the child medical treatment and released him to the parents at approximately 6:30 p.m. on 12/15/15. The Dr. instructed the parents to provide the child with the treatment every four to six hours. The mother reportedly gave the child the treatment at approximately 8:00 p.m., and then sent him to his bed to sleep. The child woke at approximately 3:00 a.m. on 12/16/15 and the mother observed he had irregular breathing. She attempted to give him another medical treatment but her effort was unsuccessful because the child became unresponsive. The mother gave the child cardiopulmonary resuscitation (CPR), 911 was contacted for assistance and EMS responded and transported the child to the hospital. The attending Dr. found the child had an illness which exacerbated the preexisting medical condition. The child was not expected to survive; he was declared brain dead 1/21/16 and pronounced dead on 1/22/16. The medical staff did not believe the "lack of proof of medical care" resulted in the child's death.

ACS obtained the child's medical records from the Richmond University Medical Center (RUMC). ACS verified the child received treatment in the Pediatric Intensive Care Unit for 38 days until the time he was declared dead. The ACS medical consultant reviewed the child's records and noted the child had remained comatose for approximately five weeks until the time of death.

NYCRO's review of the Family Services Progress Notes showed, following the child's death, ACS did not attempt to contact the family between 1/22/16 and 1/27/16. The ACS staff visited the home and observed the surviving female sibling on 1/28/16. During the visit the sibling said she was fine and she stated she did not wish to have additional conversation with ACS. The staff attempted to discuss burial expense and bereavement services with the father. However, the attempt was unsuccessful because the father said the family did not need assistance from ACS. Prior to closing the case, ACS staff observed the father and surviving female sibling on 3/3/16. During the 3/3/16 visit, the father refused the offer for bereavement services.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
N/A

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/22/2016 **Time of Death:**

County where fatality incident occurred: RICHMOND
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? 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? No
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	Adult Sibling	No Role	Male	18 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	9 Year(s)
Deceased Child's Household	Father	No Role	Male	38 Year(s)
Deceased Child's Household	Mother	No Role	Female	39 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)

LDSS Response

According to a Family Services Progress Note, on 1/28/16 ACS staff visited the case address and the father brought the surviving female sibling to the door for observation only. The documentation did not reflect that the staff was allowed to enter or observe the home conditions. The staff attempted to engage the father who declined an offer for financial burial assistance and bereavement services. The father said he would consider an ACS referral for community based service. The progress note did not include information about the mother.

ACS had obtained legal consultation to discuss the parents' failure to provide information about the child's medical history and parental lack of cooperation with substance abuse testing. The ACS attorney recommended a review of the child's hospital records to assess possible connection between the illness and preexisting medical condition, whether the illness

was avoidable with regular treatment and the method the parents had utilized to maintain prescription for the child. The attorney further recommended that ACS find out the location the parents obtained the nebulizer and whether the attending or other Dr. had observed the nebulizer to make certain it was appropriate for the child's medical needs. The attorney asked ACS to assess the timeframe in which the parents had responded to the school and any indication that delay might have exacerbated the child's suffering. Regarding the suspicion of parental substance abuse, ACS was advised to consider obtaining information from relevant collaterals including family and friends.

The hospital medical records, written on 12/16/15, reflected EMS transported the child from the school to the Richmond University Medical Center (RUMC) on 12/15/15. The attending Dr. gave the child medical treatment and a five-day course including medication to be administered every four to six hours. The medical records noted that the mother administered the treatment once after discharge from the ER and no medication was given for nine hours until the child woke and complained of trouble breathing. The parents then attempted to administer the treatment and the child became increasingly drowsy and unresponsive. The parents contacted 911 and they administered CPR until EMS arrival. Upon arrival at the home, the responders found the child had a weak pulse. EMS initiated CPR en route to the ER. According to the medical records, there was an "estimated anoxic time" of five minutes prior to initiation of CPR. The ACS medical consultant reviewed the RUMC medical records on 2/26/16. This consultant noted that the child received treatment for 38 days for the preexisting medical condition and other illness, the child remained comatose until he expired on 1/22/16. ACS documentation did not establish whether the consultant made new recommendations. The ACS staff did not conduct additional casework activity regarding the legal consultation.

Following the 1/28/16 home visit, ACS did not attempt to contact the family until the staff visited the home on 3/3/16. During the 3/3/16 visit, the father expressed feelings of sadness and he again declined the ACS offer for bereavement or other services. The ACS staff engaged the surviving sibling who said she did not have concerns. ACS closed the case on 3/4/16.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐

When appropriate, children were interviewed?	☐	☒	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ACS staff interviewed the school nurse on 12/21/15. ACS learned that the staff became aware of the child's medical condition in 2015. The staff said the parents responded to the school requests for contact when the child became ill.

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?	☐	☐	☒	☐

Explain:
The child was pronounced dead on 1/22/16 and ACS did not attempt to visit the home the assess the surviving sibling's safety until 1/28/16.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine

Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving 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: ACS closed the PPRS case on 3/4/16 after the family refused the agency's offer for services.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
The family refused the referral for bereavement and other support services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents did not make themselves available for PPRS.

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? No
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)
10/23/2015	9691 - Deceased Child, Male, 9 Years	9692 - Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	9691 - Deceased Child, Male, 9 Years	9693 - Father, Male, 38 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	9694 - Sibling, Female, 14 Years	9693 - Father, Male, 38 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	9694 - Sibling, Female, 14 Years	9692 - Mother, Female, 39 Years	Inadequate Guardianship	Unfounded	
	9691 - Deceased Child, Male, 9 Years	9693 - Father, Male, 38 Years	Inadequate Guardianship	Indicated	
	9694 - Sibling, Female, 14 Years	9693 - Father, Male, 38 Years	Inadequate Guardianship	Unfounded	
	9691 - Deceased Child, Male, 9 Years	9692 - Mother, Female, 39 Years	Lack of Medical Care	Indicated	
	9691 - Deceased Child, Male, 9 Years	9693 - Father, Male, 38 Years	Lack of Medical Care	Indicated	
	9694 - Sibling, Female, 14 Years	9692 - Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unfounded	
	9694 - Sibling, Female, 14 Years	9692 - Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	9691 - Deceased Child, Male, 9 Years	9692 - Mother, Female, 39 Years	Inadequate Guardianship	Indicated	
	9691 - Deceased Child, Male, 9 Years	9692 - Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unfounded	
	9691 - Deceased Child, Male, 9 Years	9693 - Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Unfounded	
	9694 - Sibling, Female, 14 Years	9693 - Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:
The 10/23/15 SCR report alleged that for the past several years the parents had been smoking crack cocaine and using alcohol to impairment while caring for the child and sibling on a daily basis and were therefore unable to care for the children. The report also alleged the parents left drugs accessible to the children. In addition, there was no food in the home and the children begged others for food. The sibling was often not attending school and the parents made no effort to get her to school. The situation was ongoing. The role of the adult sibling was unknown.

Determination: Indicated | **Date of Determination:** 01/08/2016

Basis for Determination:
ACS added to the 10/23/15 report the allegation of LMC and substantiated the allegations of IG and LMC of the child by the parents on the basis that the mother provided information for only one medical examination with the Dr. in October 2014. ACS was unable to obtain other information from the parents or medical provider although the child had a preexisting medical condition. The school nurse did not have records or medication to treat the child's condition in school. The child was admitted to the hospital and was in critical crisis. ACS unsubstantiated the allegations of IF/CS and

PD/AM of the children and IG of the sibling on the basis of lack of credible evidence.

OCFS Review Results:

The ACS case record reflected there was no evidence of drug use in the home. ACS found the child had a preexisting medical condition and used prescribed nebulizer. However, ACS did not attempt to observe the nebulizer. The child was hospitalized on 12/16/15 due to his preexisting medical condition and other illness. The hospital staff said the child was unable to breath on his own, he had limited brain activity and was not expected to survive. The 1/7/16 safety assessment did not identify the safety factor that placed the children in immediate danger. ACS did not enter several progress notes within the 30-day timeframe. CONNECTIONS record showed ACS did not provide notice of indication.

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

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

There were Investigation Progress Notes which were not entered within the required 30-day timeframe. These events occurred between October and November 2015 but were not entered until January 2016.

Legal Reference:

18 NYCRR 428.5(a) and (c)

Action:

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

Issue:

Predetermination/Assessment of Current Safety and Risk

Summary:

ACS inappropriately completed the Investigation Determination safety assessment document as the agency did not identify the safety factor which actually placed the children in immediate or impending danger.

Legal Reference:

18 NYCRR 432.1(aa)

Action:

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

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

In Investigation Progress Notes dated 10/23/15 and 12/18/15, ACS referenced the child's prescribed nebulizer. However, the ACS case record did not establish whether ACS and the school nurse attempted to observe the nebulizer and prescribed treatment. The ACS case record did not include updated information about the District Attorney referral which was referenced in the documentation.

Legal Reference:

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:

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

Issue:
Failure to Provide Notice of Indication
Summary:
ACS did not provide a written notice of indication to the subjects and adult other person identified in the investigation of the 10/23/15 SCR report.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

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

The parents were not known as the subject of a report more than three years prior to the fatality.

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: 12/24/2015

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: 12/24/2015

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

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐

Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☐	☒	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐

Additional information, if necessary:
N/A

Required Action(s)

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

Preventive Services History

As a result of the investigation of the 10/23/15 report, ACS found the 9-year-old child was diagnosed with a preexisting medical condition. The parents did not provide the medical history which was necessary to evaluate the symptoms, severity of the medical condition and the parents' ability to manage the child's health needs.

On 12/18/15, ACS learned that the child was admitted to the hospital on 12/16/15 for long term medical care due to serious illness. ACS opened the Family Services Stage of the case on 12/24/15. Initially, the family accepted case management and casework counseling services. On 1/22/16, ACS learned of the child's death. Between 1/28/16 and 3/3/16 ACS made two visits to the case address but was unable to fully engage the family members. ACS closed the case after the family refused services.

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

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