Child Fatality Report

Report Identification Number: NY-20-034

Prepared by: New York City Regional Office

Issue Date: Oct 09, 2020

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 03/18/2020
Initial Date OCFS Notified: 04/12/2020

Presenting Information

According to the OCFS-7065, the newborn infant was hospitalized following his birth in February 2020. The infant remained in the hospital until he was pronounced dead on 3/18/20.

Executive Summary

The family had an open services case that began on 2/22/19. The case was open to address the BM's history of substance misuse, her mental health needs, and domestic violence that occurred in her household. The family composition included the BM and two-year-old male SS. This SS was placed in foster care under an Article Ten Neglect petition filed in Family Court. He was in foster care placement when the SCR registered a report regarding the infant on 2/18/20.

ACS initiated the 2/18/20 investigation and the findings showed in February of 2020, the BM was in the home of the infant's alleged father (referred to as the BF) when she gave birth to the infant in the toilet. The infant was removed from the toilet and EMS transported the infant and BM to the local hospital. Upon arrival at the hospital, the infant was admitted and placed in the neo-natal intensive care unit as he was born prematurely at approximately 26 weeks gestation. The medical professionals diagnosed the infant with multiple medical conditions associated with prematurity. The infant remained hospitalized, his condition deteriorated and he was pronounced dead on 3/18/20.

ACS submitted 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 Services Cases. The information regarding the infant’s death was reported to OCFS under Chapter 485 of the Laws of 2006.

NYCRO contacted the New York City Office of Chief Medical Examiner and learned there was no autopsy for the infant as the death was referred to the ME for cremation only.

The ACS case record reflected the infant had three SS who were in the legal custody of their father and they resided out of New York State. There were no other children in the BM's care as the 2-year-old SS remained in foster care placement. The Family Services Progress Notes (FSPN) reflected the provider agency made frequent face-to-face contacts with the 2-year-old SS and his foster parent. This SS was up to date with medical and dental appointments and was deemed a well child.

Per the FSPN, the BM moved out of New York State on an unspecified date. On 8/25/20, during a telephone interview with the provider agency, the BM said she relocated to reside with the MA out of New York State. The BM informed the agency that she planned to return to New York.

The case remained open for foster care services at the time this fatality report was issued.

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:
There was no CPS report regarding the infant's death.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
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: 03/18/2020 **Time of Death:** 04:35 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? No
Did EMS 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: Hospitalized

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:

Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	1 Month(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)
Other Household 1	Sibling	No Role	Male	2 Year(s)

LDSS Response

Following the infant's death, ACS contacted the hospital and verified the attending physician pronounced the infant dead on 3/18/20. ACS learned that the hospital provided the BM with information for burial assistance.

On 3/18/20, ACS made a written request for the BM's prenatal record. On 4/7/20, ACS attempted to visit the medical provider's office. The progress notes reflected the office was closed.

ACS reviewed the case circumstances and noted the BM gave birth prematurely, and the infant and BM were transported to the hospital for medical care. The ACS review showed the agency interviewed an assigned medical professional, who said the infant arrived at the hospital approximately 30 minutes after he was born and the BM tested positive for marijuana at home. ACS noted the infant was DOA on arrival at the hospital, and the medical professionals resuscitated the infant. However, the infant was unable to breathe without the use of medical devices, he had a brain bleed, and was born with organs that were not fully functioning. The infant was not tested for illicit substances due to his prematurity condition. ACS added that the agency attempted to interview the MA, MGM, father of the BM's older children, and the BM's shelter case manager. ACS explained that the agency was unable to obtain credible evidence to prove the BM's actions/inactions resulted in the preterm birth and complications associated with the birth or the death of the infant.

The FSPN showed the provider agency continued to visit the SS in his foster home. The provider agency noted the SS did not have marks/bruises and was deemed a well-child, there were no hazardous conditions in the home, and the foster parent provided a minimum degree of care for the SS.

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 observed the SS in his foster home. There were no surviving children in the BM's household.

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	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☐	☒	☐	☐	☐
Economic support	☐	☐	☒	☐	☐	☐	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☒	☐	☐	☐	☐	☐	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐	☐
Health care	☒	☐	☐	☐	☐	☐	☐
Legal services	☒	☐	☐	☐	☐	☐	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐

Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☒	☐	☐	☐	☐
Child Care	☒	☐	☐	☐	☐	☐	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The SS received foster care services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The BM received therapeutic and support services.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/18/2020	Deceased Child, Male, 3 Days	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
The 2/18/20 report alleged the BM gave birth to a male infant in February 2020. The 2-year-old SS was in foster care. The SS was removed from the BM due to abuse/neglect.

Report Determination: Indicated **Date of Determination:** 04/14/2020

Basis for Determination:
ACS substantiated the allegation of IG of the infant by the BM. In the Investigation Conclusion Narrative, ACS stated the infant had preterm birth, related complications after birth, and the death of the infant was a result of the BM not providing adequate guardianship for the infant.

OCFS Review Results:
ACS interviewed the BM, observed the infant in the hospital and obtained information from collateral contacts. ACS findings showed in February of 2020, the BM was visiting the alleged BF's home when she gave birth to the infant in the toilet. The BF contacted 911, and EMS transported the infant to the hospital where he remained until he died on 3/18/20. The investigation was incomplete as ACS did not make a diligent search to contact the BF, whom ACS listed as the Secondary Caretaker in the RAP, to discuss his actions related to the infant. ACS indicated the report although the investigation was incomplete, and the evidence gathered did not support the finding of maltreatment

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

Issue:
Appropriate Application of Legal Standards (Abuse/Maltreatment)

Summary:
ACS did not appropriately apply the standards of maltreatment to the case circumstances. ACS indicated the report although the case circumstances did not reflect the BM's actions or inactions placed the infant in danger.

Legal Reference:
SSL 412(1) and 412(2)

Action:
ACS must submit a PIP 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 Investigations

Summary:
The ACS case record reflected the BF was involved in the incident pertaining to the infant's birth. However, ACS did not make diligent efforts to contact the BF to obtain information about his actions, the approximate time the BM delivered the infant, timeline of events, and other information about the case circumstances.

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

Action:
ACS must submit a PIP 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/14/2019	Sibling, Male, 2 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	No
	Other Child - Unknown, Male, 5 Years	Father, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 9/14/19 report alleged, on 9/14/19 the BF physically assaulted the BM while his 5-year-old unidentified male child was in close proximity. During the altercation, the BF busted the BM's lip. This was not the first incident of violence between the BM and BF, and BF was the primary aggressor. The BF probably had weapons in the home. The BM's role was unknown.

Report Determination: Indicated | **Date of Determination:** 11/13/2019

Basis for Determination:
ACS substantiated the allegation of IG of the 2-year-old SS by the BM as the evidence supported the finding of neglect. ACS explained that the BM left the SS with a family friend, did not plan for the child's care.

ACS unsubstantiated the allegation of IG of the BF on the basis of no credible evidence.

OCFS Review Results:
ACS interviewed the BM, who denied the allegations of the report. The BF did not make himself available to ACS. ACS visited the mother of the 5-year-old child, this mother refused to provide identifying information for the child, she denied ACS entry but permitted ACS to observe the child outside her home. ACS noted the child did not have marks/bruises.

ACS obtained evidence that showed the 2-year-old SS sustained burns while in the BM's care. ACS found the BM left the SS with a friend without making a plan for his care and did not return for about a two-week period of time. ACS obtained Family Court intervention and the judge placed the SS in LDSS custody.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/10/2019	Sibling, Male, 2 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
The 5/10/19 report alleged on 5/8/19, the BM brought the SS to the babysitter's home because she was overwhelmed. The BM brought some of the child's belongings bud did not state the length of time she planned to leave the SS in the babysitter's care. The BM could not be reached. The BM and SS resided with a maternal aunt, who had four children in home. The aunt and children had unknown roles.

Report Determination: Indicated | **Date of Determination:** 07/09/2019

Basis for Determination:
ACS substantiated the allegation of IG of the SS by the BM on the basis of credible evidence. The BM left the SS with the babysitter. The BM did not inform the babysitter of her plans to return for the SS.

OCFS Review Results:
During interviews with ACS, the BM denied the allegations of the report. She informed ACS that she left the SS with the babysitter, and she said she was overwhelmed with the care and supervision of the child. ACS noted there was an existing OP on behalf of the BM and SS against the father of the SS.

The documentation reflected on the BM retrieved the SS from the babysitter's home and the BM and SS resided with the

MA. The BM and SS then relocated to reside with the BF and ACS visited them in the BF's home. ACS noted the BF's home was clean and free of hazardous conditions.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/20/2019	Sibling, Male, 1 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 1 Years	Mother, Female, 33 Years	Lacerations / Bruises / Welts	Substantiated	
	Sibling, Male, 1 Years	Mother, Female, 33 Years	Swelling / Dislocations / Sprains	Substantiated	
	Sibling, Male, 1 Years	Other Adult - Father of SS, Male, 31 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Years	Other Adult - Father of SS, Male, 31 Years	Lacerations / Bruises / Welts	Substantiated	
	Sibling, Male, 1 Years	Other Adult - Father of SS, Male, 31 Years	Swelling / Dislocations / Sprains	Substantiated	
	Sibling, Male, 1 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 1 Years	Other Adult - Father of SS, Male, 31 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The report alleged on 2/20/19, during the night, the BM and father of the SS were involved in a physical altercation in the presence of the SS. The SS sustained an abrasion on his forehead. There was an older bruise on the SS's left lower leg. The parents appeared to be under the influence.

Report Determination: Indicated | **Date of Determination:** 04/15/2019

Basis for Determination:
ACS substantiated the allegations of IG, L/B/W, and S/D/S of the SS by the BM and father of the SS. ACS explained that the BM held the SS in her arms while she engaged in a physical altercation with the father. The SS sustained an injury as a result of the father hitting the BM while she held the SS.

ACS substantiated the allegation of PD/AM of the SS by his father on the basis of finding that reflected the parents were under the influence of some substance.

ACS unsubstantiated the allegation of PD/AM of the SS by the BM on the basis of no credible evidence. The BM submitted a random drug test and the results were negative for all substances.

OCFS Review Results:
On 2/21/20, ACS interviewed LE and found the BM and father had a physical altercation during which the SS sustained an abrasion above his right eye. Per LE's account, the BM said she was holding the SS when the father pushed and choked her, the father sustained injuries, and the BM and father were arrested.

The SS received treatment and following medical clearance, ACS conducted an emergency removal and placed him in the care of a family friend, who was the babysitter. ACS obtained Family Court intervention and the judge granted continued placement with the babysitter. On 2/26/20, the judge released the SS to the BM with ACS Court Ordered Supervision, and an OP against the father.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/20/2018	Sibling, Male, 11 Months	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 11 Months	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The report alleged the BM frequently became intoxicated while caring for the SS. When the BM was intoxicated she gave the SS alcohol. It was unknown if the SS became ill as a result. The BM was out very late in the evening with the SS while she was intoxicated. The BM was diagnosed with mental health conditions, she was not taking her medication and as a result was unstable. The BM was unable to adequately care for the SS.

Report Determination: Indicated **Date of Determination:** 05/19/2018

Basis for Determination:
ACS substantiated the allegations of the report on the basis of credible evidence that showed the BM misused alcohol. ACS explained that the BM was intoxicated while caring for the SS, and left him in the care of another individual for approximately one week without proper planning. ACS added that the BM left New York State and did not provide information about her whereabouts and medication management.

OCFS Review Results:
ACS interviewed the BM, observed the SS and assessed the home conditions. The BM denied the allegations of the report, ACS observed the BM's prescribed medication and discussed her treatment plan. ACS noted the SS did not have marks/bruises, the family resided in a shelter and there were no hazardous conditions in the home. During the investigation, the BM informed ACS she took the SS to reside with the MA out of New York State.

ACS received information from pertinent collateral contacts. The findings showed the BM misused alcohol, became impaired while caring for the SS and left him with an individual for approximately one week. ACS did not contemporaneously enter progress notes.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
ACS did not contemporaneously enter the Investigation Progress Notes. Events occurred on 3/20/18 and 4/10/18 but were not entered until 5/19/18.

Legal Reference:
18 NYCRR 428.5

Action:
ACS must submit a PIP 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/17/2018	Sibling, Male, 8 Months	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes

	Sibling, Male, 8 Months	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
The 1/17/18 report alleged the BM was diagnosed with mental health conditions. The BM was prescribed medication. It was questionable whether or not the BM consistently took her prescribed medication. On 12/7/17, the BM was intoxicated while being the sole care provider for the SS. On 1/17/18, the BM was in an agitated state but the SS was with another individual at the time.

Report Determination: Unfounded **Date of Determination:** 03/19/2018

Basis for Determination:
ACS unsubstantiated the allegations of the report on the basis of no credible evidence.

OCFS Review Results:
ACS addressed the allegations of the report with the BM. The BM denied she became intoxicated and she said at the time she used alcohol the SS was not in her care. She said her older children resided with their father out of New York State. The investigative findings reflected that during the time the BM used alcohol, the SS was in the care of a family resource, the BM received treatment for her mental health conditions, and the family resided in a shelter where they received services.

ACS completed the Risk Assessment Profile (RAP). However, the RAP did not reflect the SS was under one year old, the BM was involved in threatening incidents and the family had unstable housing.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP did not reflect the SS was under one year old at the time of the 1/17/18 report, the BM was involved in threatening incidents within two years prior to the investigation, and the family had unstable housing.

Legal Reference:
18 NYCRR 432.2(d)

Action:
ACS must submit a PIP 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.

[redacted]

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

There is no CPS investigative history 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 Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 02/22/2019

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

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

Casework Contacts

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

Services Provided

	Yes	No	N/A	Unable to Determine
Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

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

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The FSPN reflected ACS and the provider agency did not contemporaneously enter progress notes.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP 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.

Preventive Services History

The family received preventive services under an Article Ten Neglect petition that ACS filed in Family Court on 2/21/19. During the hearing, the judge released the SS to the BM with Court Ordered Supervision and an order of protection against the father of the SS. The BM and SS resided in temporary housing and then relocated to reside with the MA. The BM received PPRS, individual counseling through a community-based agency, and support from the babysitter who was listed as a resource person.

The BM was not compliant with the service plan requirements. The father did not complete batterer's accountability and individual counseling to address domestic violence. The FASP reflected there were concerns about visitation between the SS and his father.

The preventive services ended when the judge remanded the SS to LDSS custody. The agency completed the required number of visits to meet the program requirement. ACS and the provider agency did not contemporaneously enter progress notes.

Foster Care Placement History

ACS conducted an emergency removal of the SS from the BM's home on 9/16/19. The SS was remanded to ACS and placed in foster care.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?
☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/17/2019	There was not a fact finding	Foster Care Placement to Continue
Respondent:	055109 Mother Female 33 Year(s)	
Comments:	The judge remanded the SS to LDSS custody. The SS resided in a non-kinship foster home.	

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