Child Fatality Report

Report Identification Number: NY-20-107

Prepared by: New York City Regional Office

Issue Date: May 28, 2021

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: 3 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 11/29/2020
Initial Date OCFS Notified: 11/29/2020

Presenting Information

The SCR registered three reports regarding the death of this three-year-old male child. The first report alleged at 9:00 AM on 11/29/20, the mother checked the three-year-old male child and realized that the child was cold to the touch. It was unknown if the child was unresponsive or if he was exhibiting any other signs of distress. At about noon, the child was unresponsive and 911 was called. The report alleged the subject child was rushed to the hospital and was pronounced dead at 1:18 PM. The report further alleged the mother was the last individual to see the child alive; yet, there was no further information regarding when that was. The report also stated the grandmother and another child were also present in the apartment at the time. The child was diagnosed with a mild medical condition and was born prematurely, but there was no information to suggest that the child's medical concerns contributed to his death. Since the mother and grandmother provided no explanation for the child's death, they were listed as alleged subjects in the report.

A second report alleged on 11/28/20 at approximately 11:00PM the mother put the child to bed and on 11/29/20 when she checked the child he was cold to the touch and blue in color. The report alleged he was an otherwise healthy child. Further, the mother provided no explanation for the cause of the child's death. The report alleged the child died in the mother's care between 11:00PM on 11/28/20 and noon 11/29/20. The report stated the mother provided multiple timelines of events leading up to finding the child and provided at least two different stories regarding the number of times she checked the child.

The third report alleged on 11/29/20 the mother found it strange that the three-year-old child was still asleep at 9:00AM. At about 11:30 AM, the mother checked the child and found him not breathing. The mother called for emergency medical assistance. According to the narrative, the child appeared blue in color, had blood coming from his nose, and was not breathing. This report alleged the child was otherwise healthy and the mother had no explanation for his death. The roles of a six-year-old child and the parent substitute were unknown.

Executive Summary

This fatality report concerns the death of the 3-year-old male child on 11/29/20. Three reports were registered by the SCR on that same date, with allegations of DOA/Fatality and Inadequate Guardianship of the child by the child’s mother. The Administration for Children’s Services (ACS) received the report and investigated the child’s death. An autopsy was completed; however, the results were pending at the time of the issuance of this report.

At the time of the child’s death, he resided with his mother, and a six-year-old surviving female sibling out of state.

The investigation revealed that on 11/28/20, the mother came from out of state to visit the parent substitute and his children. The visit took place in a friend’s apartment. At about 11:00PM, the children went to sleep. The parents went to sleep in a separate room. On 11/29/20 at about 11:30AM when the mother awoke, the parent substitute and his children had already left. The three-year-old child was found unresponsive shortly thereafter. Emergency services personnel were called to the home on 11/29/20 at approximately 12:04PM after the child was found unresponsive. The child was transported to the hospital and was pronounced dead at 1:18PM.

Initially, it was reported the child had an injury and the diagnosis was rear of head questionable non-depressed linear occipital skull fracture. However, further exploration revealed the child had no fractures, no trauma to his body, no

bruising, and no signs of any healing injuries.

The six-year-old surviving sibling was assessed, and based on the information obtained, ACS completed a protective removal of the child. ACS filed an Article 10 Petition of Neglect in Family Court naming the mother as the respondent. The court granted a remand of the sibling. The surviving sibling was placed in non-kinship foster care and is receiving bereavement counseling.

Prior to making a determination on the case ACS enlisted the services of the out of state child protection agency to conduct visits to the mother's home and to interview the mother. ACS adhered to approved protocols for a joint investigation with law enforcement, and they made diligent attempts to interview the adults who had been in the home on the night prior to the child's death. ACS spoke to family members, law enforcement, the medical examiner's office, hospital staff and the DA's office. Law enforcement conducted interviews with mother and other relatives to assess the possible criminal elements of their investigation.

On 1/28/21, ACS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship of the child by the mother and the grandmother of the parent substitute who was also named the subject of the report, as there was no credible evidence the mother and parent substitute's grandmother failed to meet a minimum standard of care. Additionally, there was no evidence to suggest the parent substitute's grandmother was a caretaker or person legally responsible.

ACS added and substantiated the allegation of Inadequate Guardianship of the surviving sibling by the mother. ACS documented concerns that could place the child in immediate or impending danger of serious harm if the child continued to reside in the mother's home and cited the mother's mental health, her substance use and/or misuse and the condition of the mother's home as described by the out of state agency.

The report was indicated.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
Sufficient information gathered to make determination for all allegations, including those on the intake report as well as the allegation of Inadequate Guardianship, identified in the course of the investigation. The determination made by the district to indicate the report was appropriate.

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:
The level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion, was commensurate with the case circumstances.

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:	The 24-Hour safety assessment was not completed timely as it was not completed until 12/1/20.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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:	Timely/Adequate Case Recording/Progress Notes
Summary:	Notes were not entered contemporaneously. For example, an event occurred 11/30/20 but was not entered until 1/28/21.
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.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30Day Child Fatality Summary Report reflected that the Summary of Past Service History was incomplete as the documentation only reflected the SM and her family. ACS did not include the PS GM as she was also a subject of the report.
Legal Reference:	CPS Program Manual, Chapter 6, K-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:	Pre-Determination/Supervisor Review

Summary:	The 12/29/20 safety assessment was inadequate. The associated comment of the selected safety factor regarding the SM's clinical health did not reflect how her condition negatively impacted her ability to supervise, protect, and/or care for the CHN.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)
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:	Timely/Adequate Seven Day Assessment
Summary:	The 12/6/20 safety assessment was inadequate. The associated comment of the selected safety factor regarding the SM's clinical health did not reflect how her condition negatively impacted her ability to supervise, protect, and/or care for the CHN.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/29/2020 **Time of Death:** 01:18 PM

Time of fatal incident, if different than time of death: 11:45 AM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 12:04 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **Awake**

Total number of deaths at incident event:

Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	6 Year(s)
Other Household 1	Other - Unknown	Alleged Perpetrator	Female	76 Year(s)
Other Household 1	Other - SM's Paramour	No Role	Female	31 Year(s)

LDSS Response

ACS began their investigation upon receipt of the SCR reports on 11/29/20. They gathered information from the sources of the reports, law enforcement, hospital staff, and the District Attorney's office. ACS staff observed the forensic interview conducted at the Child Advocacy Center.

The six-year-old surviving sibling was interviewed, and she reported on 11/29/20 she woke up before the subject child and heard the mother screaming that the subject child was dead. The sibling added that on 11/28/20 while they were in the friend's home, the subject child "got in trouble" as he "put something in his mouth that was only supposed to be for adults." She said the subject child felt sick" like he was going to vomit." The child said the mother hit the subject child on his lips three times with an open hand. The mother also hit the subject child once on his back with such force that the child fell on the floor. The sibling said the subject child cried and the mother then told him to lay down and sleep or she would hit him again. She said the subject child went to sleep on the couch next to the mother. She said in the morning when she awoke the parent substitute left but returned with breakfast and left again.

The mother stated she came from out of state to visit the parent substitute and his children. The visit took place in a friend's apartment. The mother said sometime before 11:00PM the subject child vomited because he ate too much food and candy. She cleaned up the child and at about 11:00PM, the children went to sleep. Shortly thereafter both she and the parent substitute went to their bedroom. On 11/29/20 at about 11:30 AM when she awoke, the parent substitute and his children had already left. The mother said the six-year-old child woke up before the subject child. The mother said it was unusual because the subject child was usually the first to rise in the mornings. The mother reported she did not think anything of it, since they had all slept late. The mother reported she and the six-year-old sibling went into the living room. She said she made a call to the parent substitute and when she checked the subject child she realized that he was cold and unresponsive and she realized then that he was dead. The mother reported that she called 911. Emergency services personnel were called to the home on 11/29/20 at approximately 12:04 PM. They arrived at 12:22PM. The child was transported to the hospital and was pronounced dead at 1:18 PM.

Law enforcement personnel who were present for the interview indicated according to information obtained, on 11/28/20 during the night, the adults in the home were drinking excessively while watching a fight on television despite the mother's denial of alcohol use. No arrests would be made pending the results from the Medical Examiner. The case documentation did not reflect if the Medical Examiner was provided the information from the six-year-old sibling.

Following the interview at the Child Advocacy Center, the surviving sibling was removed from the mother's care. Initially, the sibling was removed due to concerns that the subject child had sustained a skull fracture, which was later proven to be incorrect. However, ACS had other concerns regarding the mother's drinking, her untreated clinical health, the impact of

the subject child's death, and concerns about the mother's home and living conditions out of state. ACS provided the mother with the Notice of Existence of the report and the Notice of Temporary Removal. The following day ACS filed the Article 10 Petition in Court seeking a remand of the surviving sibling.

On 11/29/20 ACS staff, the Medical Examiner and detectives from the NYPD completed a walkthrough of the apartment where the child died. The Medical Examiner indicated the autopsy was scheduled for 11/30/20. A discussion of the preliminary skeletal scan ensued, and it was believed the injury to the child's head was suspicious. However, on 11/30/20, the Medical Examiner, reported the child had no fractures, no external or internal trauma to his body, and no signs of any healing injuries. His tonsils were somewhat swollen. The Medical Examiner specified that a toxicology screen was pending.

Also on 11/29/20, ACS contacted the hospital where the child had been taken and learned Emergency Medical Services ambulance arrived at 12:22PM on 11/29/20. The child's eyes were dilated, and no respiratory efforts were made. The ambulance arrived at the hospital at 12:37PM. According to the physician, it was reported the child was found in the home "apneic", pale, cold, unresponsive, unconscious, and without a pulse or blood pressure. The child body was in rigor mortis. The time of death was 1:18PM.

The mother was reinterviewed on 11/29/20, and she provided information regarding past Child Welfare history outside of NYS. She also informed ACS of a prior fatality of her newborn son in 2013. According to the mother the child died two hours after birth. The mother denied domestic violence in her current relationship.

ACS's case documentation reflected the surviving sibling was aware of the death of her brother and indicated the subject child was in heaven. The surviving sibling also expressed that she was sad because of his death and the death of her other brother in 2013.

On 11/30/20, ACS learned that personnel from the Fire Department of New York emergency personnel were the first responders and they arrived on scene at 12:04PM on 11/29/20. The child was transported to the hospital and was pronounced dead.

Also, on 11/30/20, ACS completed an assessment of the mother's drug and alcohol use and determined the mother needed Credentialed Alcoholism and Substance Abuse Counselor intervention to address her alcohol use. A referral was completed for the mother.

On 12/1/20, ACS visited the child in care. The child repeated that she was saddened by the death of her brothers and told the ACS staff she did not want to return to her mother's care. No context was provided for the child's statement. After visiting the child, the ACS staff attempted to conduct an assessment of the parent substitute's children. The children's mother refused ACS access to the children. No further action was taken to see the children. ACS also learned the parent substitute had been arrested on 11/29/20 on charges unrelated to the fatality.

On 12/4/20 and again on 12/7/20, ACS enlisted the services of the out of state CPS to conduct a courtesy visit to the mother's home. According to the documentation, the mother's two-bedroom home was described as "very cluttered and filthy." Additionally, there were medicine bottles all over the floor and on the television stand which was easily accessible to the children. Further it was noted there was a strong smell of marijuana in the home. The out of state Agency stated although there were no serious immediate safety concerns risk issues existed.

On 12/11/20, at a court hearing the court granted ACS's 107 application and remanded the child to the Commissioner of ACS. The Court also granted supervised visitation between the mother and the child. ACS noted the six-year-old surviving sibling was continuing her remote schooling.

On 12/21/20, a transition meeting was held with the agency's Case Planner. Bereavement and individual counseling were

scheduled for the six-year-old surviving sibling who was refusing to see the mother. The service plan for the mother included a clinical health evaluation, and drug screening. A Family Services Stage was opened to document the mother's progress in services.

On 1/12/21, a Post Removal Conference was held. The mother participated in the planning for the child. It was documented the mother was maintaining the scheduled visits. It was documented the child was adjusting well in the foster home.

Despite attempts to interview the parent substitute and his grandmother, ACS was not successful. Family members refused to allow CPS access to the grandmother and the parent substitute did not make himself available for any interviews.

ACS inquired about the fathers of the children and learned none of them were involved in the lives of the children. The mother reported there was domestic violence with the father of the six-year-old child who was arrested in March due to domestic violence concerns and the father of the subject child had not be involved since the child was one year old.

On 11/30/20, 12/6/20, 12/29/20, and 1/26/21, ACS completed Safety Assessment forms and documented one or more safety factors were present that placed the surviving sibling in immediate or impending danger of serious harm, and removal to foster care was necessary to control the situation and protect the child.

On 1/22/21 ACS convened a Child Safety Conference and decided the mother would be referred for a mental health evaluation and family therapy.

On 1/28/21, ACS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship of the subject child by the mother and the parent substitute's grandmother as there was no credible evidence the mother and parent substitute's grandmother failed to meet a minimum standard of care. Additionally, there was no evidence to suggest the parent substitute's grandmother was a caretaker or person legally responsible.

ACS added and substantiated the allegation of Inadequate Guardianship of the surviving sibling by the mother. ACS documented concerns that could place the child in immediate or impending danger of serious harm if the child continued to reside in the mother's home and cited the mother's mental health, her substance use and/or misuse and the condition of the mother's home as described by the out of state agency.

The report was indicated.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

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.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056863 - Deceased Child, Male, 3 Yrs	056864 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
056863 - Deceased Child, Male, 3 Yrs	056864 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
056863 - Deceased Child, Male, 3 Yrs	056866 - Other - Unknown, Female, 76 Year(s)	DOA / Fatality	Unsubstantiated
056863 - Deceased Child, Male, 3 Yrs	056866 - Other - Unknown, Female, 76 Year(s)	Inadequate Guardianship	Unsubstantiated
056865 - Sibling, Female, 6 Year(s)	056864 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
School	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☒	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
While ACS made diligent efforts, neither the parent substitute nor the parent substitute's grandmother who was a subject of the report was interviewed.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐

Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☒	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
During the course of the investigation sufficient information was gathered to assess risk to the surviving child in the household.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☒	☐	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
On 11/29/20, ACS conducted an emergency removal of the six-year-old surviving sibling from the mother's care.

Legal Activity Related to the Fatality

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

☒ Family Court ☐ Criminal Court ☐ Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
11/30/2020	There was not a fact finding	Article 10 Remand
Respondent:	056864 Mother Female 28 Year(s)	
Comments:	On 11/29/20, ACS conducted a removal of the six-year-old surviving sibling and provided the mother with the Notice of Temporary Removal of Child and Right to a Hearing. On 11/30/20, an Article Ten Neglect petition was filed. The documentation reflected that a 1022 Petition was filed and a remand of the six-year-old surviving sibling was granted .	

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACS referred the mother for a drug test on 12/9/20. The mother said she did not attend on the advice of her attorney. Her attorney also advised her against signing medical release documents. The Case Planner indicated the agency would make a referral for the mother to have an evaluation to exclude any clinical health conditions. The Case Planner also stated the agency would make a referral for individual and bereavement counseling for the surviving sibling as a result of the fatality and the child not wanting to see the mother.

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 six-year-old surviving was placed into foster care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS referred the mother for a drug test on 12/9/20. The mother did not attend on the advice of her attorney. Her attorney also advised her against signing medical documents.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	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?	No

CPS - Investigative History Three Years Prior to the Fatality

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

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

The mother was not known to the SCR or ACS as a subject. The subject child and his 6-yo surviving sibling were not known to the SCR or ACS.

The grandmother of the PS was known to the SCR and ACS as a subject in two reports both registered on 4/9/13. The allegations of the 4/9/13 report were IG, II, L/B/W, and M/FTT of the PS who was then 11 years old child by his grandmother and mother, and IF/C/S and LMC by the mother. On 6/8/13, the report was unsubstantiated and closed. A referral was made to community based services. The subsequent report registered on 4/9/13 was closed as a duplicate and consolidated into the initial investigation.

Known CPS History Outside of NYS

The documentation reflected the mother had known CPS investigations outside of NYS. The concerns of the report revolved around the mother's clinical health and the level of supervision provided to her children. .

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