# Child Fatality Report

## Report Identification Number: NY-21-012

**Prepared by: New York City Regional Office**

**Issue Date: Aug 06, 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 | **Jurisdiction:** Queens | **Date of Death:** 02/04/2021
**Age:** 10 day(s) | **Gender:** Male | **Initial Date OCFS Notified:** 02/04/2021

### Presenting Information

The SCR report alleged the SC was unusually irritable during the morning of 2/3/21 and the parents had difficulty feeding the SC throughout the day. The SF left the SC in the sole care of the SM at 6:00PM on 2/3/21 to attend work. The SF returned on 2/3/21 around 10:00PM and found the SC to be choking, gurgling, lethargic and limp. The SF contacted 911 at an unknown time after he arrived home. EMS responded to the home and performed CPR. The SC was then transported by EMS to the hospital at 12:15AM on 2/4/21. At the hospital, the SC was medically examined and found to be suffering from hypothermia with a body temperature of 93 degrees; he was in full cardiopulmonary distress. The hospital continued to perform CPR and he was subsequently intubated. The SC was pronounced dead at 6:37AM on 2/4/21. The SC was an otherwise healthy CH. The report stated the parents failed to provide any explanation regarding the SC's death.

### Executive Summary

This fatality report concerns the death of a 10-day-old male subject child that occurred on 2/4/21. A report was made to the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child’s parents. The New York City Administration for Children’s Services (ACS) received the report and investigated the child’s death. An autopsy was completed; however, the final report had not yet been released at the time of the issuance of this report.

At the time of the child’s death, he resided with his mother and father and two surviving siblings, ages five years old and one year old.

The investigation revealed during the overnight of 2/2/21 into 2/3/21 the subject child suddenly became inconsolable and would neither eat nor sleep. The child remained fussy despite attempts to soothe him. The parents described the subject child's behavior as unusual since the subject child normally slept for 3-4 hours once he was fed and his diaper was clean and dry. Between 8:30PM and 8:40PM on 2/3/21, the subject child's father attempted to feed the subject child a bottle; however, the subject child would not take the bottle. The father burped the child and at the time the child spat out a thick white liquid. Shortly thereafter, white liquid came from the child's nose. The father called emergency services. An ambulance arrived at the home and transported the child to a local hospital where he was pronounced dead. The two SSs were in their bedroom preparing for bed and did not witness the events.

On 2/5/21, the ME reported there was no trauma to the subject child. The ME did not suspect any form of child abuse or neglect.

From the time the investigation began to the time of its closure, ACS interviewed family members and collateral sources. Law enforcement found no criminality regarding the death of the child, and medical providers noted no concerns surrounding the child’s care leading up to the incident.

On 2/8/21, ACS opened a service case. However on 2/17/21, the mother informed ACS she no longer wished to participate in preventive services. The FSS was closed on 3/26/21

On 2/24/21, ACS's Family Court Legal Service (FCLS) indicated there was no legal basis on which to file a Petition of Neglect against the parents.

On 3/26/21, ACS unsubstantiated the allegations of DOA/Fatality and IG by the parents of the subject child on the basis of no credible evidence. ACS documented the subject child suddenly became ill and died. The ME indicated there was no trauma to the child's body and law enforcement made no arrests as there was no evidence of criminality by the parents. The report was unfounded.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

**Determination:**

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

**Explain:**
NA

**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 record reflected supervisory consultations throughout the investigation.

### Required Actions Related to the Fatality

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

| | |
|---|---|
| **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 30-Day Child Fatality Summary Report was incomplete. The summary of the past service history did not reflect CPS history/involvement. |
| **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:** | Adequacy of Documentation of Safety Assessments |
| **Summary:** | While the safety of the SS was adequately assessed within the 24-Hour timeframe, the documentation of the assessment form was incorrect. The safety assessment reflected the safety of the SC not the SS's. |
| **Legal Reference:** | 18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b) |
| **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:** | Contact/Information From Reporting/Collateral Source |
| **Summary:** | The documentation did not reflect the source of the report was interviewed regarding the incident. |
| **Legal Reference:** | 18 NYCRR 432.2(b)(3)(ii)(b) |
| **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:** 02/04/2021 **Time of Death:** 06:37 AM

**Time of fatal incident, if different than time of death:** 10:00 PM

**County where fatality incident occurred:** Queens
**Was 911 or local emergency number called?** Yes
**Time of Call:** Unknown
**Did EMS 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: choking, gargling, lethargic and limp

**Did child have supervision at time of incident leading to death?** Yes
**At time of incident was supervisor impaired?** Not 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 | 10 Day(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 29 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 28 Year(s) |
| Deceased Child's Household | Sibling | No Role | Female | 5 Year(s) |
| Deceased Child's Household | Sibling | No Role | Male | 1 Year(s) |

**LDSS Response**

On 2/20/21, ACS received the SCR report regarding the death of SC. ACS initiated their investigation within 24 hours and coordinated their efforts with their MDT. ACS learned there were two SSs who resided in the household.

On 2/4/21, LE reported there was no evidence of shaken baby syndrome and no criminality was suspected. Later, ACS reviewed the account the family provided to LE and determined the parents accounts remained consistent. According to the parents, during the overnight of 2/2/21 into 2/3/21 the subject child suddenly became inconsolable and would neither eat nor sleep. The child remained fussy despite attempts to soothe him. The parents described the subject child's behavior as unusual since the subject child normally slept for 3-4 hours once he was fed and his diaper was clean and dry. Between 8:30PM and 8:40PM on 2/3/21, the subject child's father attempted to feed the subject child a bottle; however, the subject child would not take the bottle. The father burped the child and at the time the child spat out a thick white liquid from his mouth. Shortly thereafter, white liquid came from the child's nose. The father called emergency services. An ambulance arrived at the home and transported the child to a local hospital where he was pronounced dead. The two SS's were in their bedroom preparing for bed and did not witness the events.

On 2/4/21, the hospital social worker (SW) said when EMS arrived, they found the SC lethargic and gurgling from the mouth. The SC body temperature was 93 degrees and he was experiencing hypothermia.

On 2/5/21, ACS contacted the mother's service provider who reported there were no concerns regarding the SM's clinical health and her ability to care for the SSs.

On 2/5/21, the SM's cousin said when she arrived at the home, the SF was holding the SC and feeding him. The SC was not that fussy but acted "strange" by making weird noises and would not latch onto the bottle. The cousin said she advised the SM to take the SC to the hospital and the SM said she would take him. She did not have concerns regarding the SM's ability to care for the SSs.

On 2/8/21, ACS spoke with the 5-yo SS's previous day care provider. The provider indicated the SS was always nicely dressed and clean, and there were never any marks/bruises on the child.

On 2/17/21, the SM told ACS the SF had relocated to the PGM's home. The SM also indicated she no longer wanted

preventive services, but would continue with her service provider for grief counseling.

On 2/23/21, ACS referred the SF to a provider agency and requested a daycare voucher for the 1-yo SS.

Throughout the investigation, ACS spoke with the ME, LE, and SC's medical providers. There were no criminal charges brought against the parents regarding the fatality. Face-to-face and virtual home visits were completed and there were no safety hazards observed. There were no concerns expressed by family members or collateral sources regarding the care of SC. ACS offered the family burial assistance and referrals for grief and bereavement counseling. There was no evidence gathered to support that the parents' actions or inaction led to the death of SC, and therefore, ACS unsubstantiated the allegations and closed the case.

## 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 the NYC region.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 057555 - Deceased Child, Male, 10 Days | 057556 - Mother, Female, 28 Year(s) | DOA / Fatality | Unsubstantiated |
| 057555 - Deceased Child, Male, 10 Days | 057556 - Mother, Female, 28 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 057555 - Deceased Child, Male, 10 Days | 057557 - Father, Male, 29 Year(s) | DOA / Fatality | Unsubstantiated |
| 057555 - Deceased Child, Male, 10 Days | 057557 - Father, Male, 29 Year(s) | Inadequate Guardianship | Unsubstantiated |

## CPS Fatality Casework/Investigative Activities

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **All children observed?** | ☒ | ☐ | ☐ | ☐ |
| **When appropriate, children were interviewed?** | ☒ | ☐ | ☐ | ☐ |
| **Alleged subject(s) interviewed face-to-face?** | ☒ | ☐ | ☐ | ☐ |
| **All 'other persons named' interviewed face-to-face?** | ☐ | ☐ | ☒ | ☐ |
| **Contact with source?** | ☐ | ☒ | ☐ | ☐ |

| All appropriate Collaterals contacted? | ☐ | ☒ | ☐ | ☐ |
|---|---|---|---|---|
| First Responders | ☐ | ☒ | ☐ | ☐ |
| **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:**

The documentation reflected ACS attempted several times to speak with the EMS Liaison.

## 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:**
Sufficient information was gathered to assess risk to all surviving children 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?** | ☐ | ☒ | ☐ | ☐ |

**Explain as necessary:**
On 2/24/21, ACS obtained a legal consultation with Family Court Legal Service (FCLS) who did not believe there was legal basis to file a neglect petition.

## 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** | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Other, specify:** PPRS

**Additional information, if necessary:**
The documentation reflected ACS provided the mother with a daycare voucher.

**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 was referred to a service provider for bereavement counseling.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
The documentation reflected ACS provided the mother with a daycare voucher. The father was referred to a provider agency.

## 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 |

### 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) |
|---|---|---|---|---|---|
| 11/01/2019 | Sibling, Female, 2 Years | Mother, Female, 26 Years | Inadequate Guardianship | Unsubstantiated | Yes |

**Report Summary:**
The 11/1/19 SCR report alleged on 10/31/19, the SM was behaving erratically in the presence of the 3-yo CH. The SM forcefully grabbed the CH from the father and proceeded to physically assault the father. The SM scratched the father on his face, leaving a scratch mark. It was unknown whether the CH was harmed due to the assault.

**Report Determination:** Unfounded | **Date of Determination:** 12/31/2019

**Basis for Determination:**
ACS's investigation revealed the 3-yo CH was receiving adequate care. The SM was not observed to be violent or angry around ACS nor did the 3-yo seem fearful of the SM. The 3-yo denied any form of discipline; she stated that the SM was mean but could not elaborate on that for ACS. The SM denied physical discipline in the home. ACS also counseled the SM about not interfering with the father's parental rights.

**OCFS Review Results:**
ACS initiated the report in a timely manner and made the contacts with the family and collaterals. ACS interviewed the subject of the report and observed the child. The investigation was completed timely. There was evidence of supervisory involvement.

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

**Issue:**
Contact/Information From Reporting/Collateral Source

**Summary:**
The documentation did not reflect ACS interviewed LE as the SM stated LE was at her home on Halloween as the SF said she scratched him.

**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(b)

**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. There were events that occurred on 11/18/19 but were not entered until 12/30/19.

**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.

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

While the SF was not known to the SCR or ACS as a subject, the mother was known as a subject in two reports dated 2/9/16 and 7/5/16.

The allegations of the 2/9/16 report were IG and Other of the 5-yo SS by the SS's father and Other by the SM. On 4/6/16, ACS substantiated the allegation of IG by the father. ACS unsubstantiated the allegations of Other by the SM and father. The allegation of the 7/5/16 report was IG of the 5-yo SS by the parents of the SS. On 7/11/16, ACS filed an Article Ten Petition of Neglect in Family Court naming the father of the SS as the respondent. On 8/12/16, ACS indicated the report. ACS substantiated the allegation of IG pertaining to the father of the SS and unsubstantiated the allegation of IG regarding the SM.

**Known CPS History Outside of NYS**

There was no known CPS History outside of NYS.

**Preventive Services History**

During the 2/9/16 investigation, ACS opened a Family Service Stage (FSS) on 4/5/16 in response to a COI regarding the parents and the 5-yo SS. The FSS was closed on 5/24/16.

On 6/23/16, another FSS was opened. The Family Court ordered a Court Ordered Investigation (COI); ACS was directed to update its previously submitted report. The FSS was closed on 7/13/16.

During the 7/5/16 investigation, ACS opened an FSS on 7/8/16 to monitor services implemented as a result of domestic violence in the home. The family service plan included: clinical services and parenting training for the SM and father of the SS. The service plan for the 5-yo SS included: case management services and early intervention. There was an order of protection issued at Family Court for the SM against the father and the court allowed supervised visits for the father with the 5-yo SS. The visits were supervised by the PGGM. The 10/3/17 FASP reflected the father completed his services and tested negative for all substances. COS ended 10/2/17. The 5-yo remained in the care of the SM and was safe at that time. The FSS was closed on 10/3/17.

On 9/21/17, the father of the 5-yo SS filed a Petition for Joint Custody and Visitation and as a result, on 11/20/17, an FSS was opened to address the COI.

**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