Child Fatality Report

Report Identification Number: NY-16-097

Prepared by: New York City Regional Office

Issue Date: May 30, 2017

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	

Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 09/11/2016
Initial Date OCFS Notified: 09/11/2016

Presenting Information

The 9/11/16 report alleged that on 9/11/16, the SC passed away. The grandmother was the sole caretaker of the SC during this period of time. The grandmother observed the SC was not breathing, called 911, and transported the SC to Wyckoff Hospital at about 12:29 AM. Upon arrival, the SC was in severe respiratory distress, and her skin appeared ashy and white in color. The SC was later pronounced dead at Wyckoff Hospital at 4:30 AM (9/11/16).

Executive Summary

The 3-month-old female infant (SC) died on 9/11/16. As of 3/16/17, NYCRO has not received a copy of the autopsy report.

The allegations of the 9/11/16 report were DOA/Fatality and IG of the SC by the PGM.

Prior to her death, the SC was released to the PGM on 9/2/16 by Kings County Family Court (KCFC). ACS filed an Article Ten Neglect petition in KCFC on behalf of the SC on 9/1/16, naming the parents as the respondents.

According to the PGM, the SC had been in her care since 8/31/16 when she picked up the SC from the Precinct after the parents were arrested. On 9/11/16, LE informed ACS that on 8/31/16, a search warrant was executed in a residence; the parents and SC were in the home where a gun was recovered. The parents were charged with criminal possession of firearm. The was also a dog in the home that was in very poor condition. Subsequently, the SC was released to the PGM.

ACS learned that the PGM reported that on 9/10/16, she was the only person who provided care for the SC, and the SC appeared to be fine throughout the day. The only time the SC cried was when she was hungry. At about 9:30 PM, the SC awoke and was crying and the PGM prepared a bottle for the SC. At her 9:30 PM feeding, the SC drank a small amount of formula; usually she drank the entire two ounces, and she continued to cry. PGM said the SC felt warm as if she was beginning to have a fever, and the SC placed her fist in her mouth while crying. The PGM believed this was a sign of teething so she held and comforted her. While holding her, the PGM saw that the SC had difficulty breathing. She saw the SC gasping for air, so she told the paternal great aunt (PGA) to call 911. The EMS operator told the PGM to remove the SC's clothes. When EMS arrived, the SC was transported to the hospital. The PGM said the SC did not show any signs of illness prior to 9:30 PM on 9/10/16. The PGM asked the BF to contact the BM.

The BM said she was sleeping at a friend's home, and the BF came to the friend's home and told her to go to the hospital as the SC was sick.

On 9/14/16, LE informed ACS that the 911 call came in on 9/10/16 between 9:00 PM and 10:00 PM. LE said the ME preliminary findings showed there was no suspicion regarding the SC's death. The home was assessed by LE and the ME staff. The SC had only been in the home nine days. There was a bassinet in the home. LE said the attending Dr. who treated the SC also said everything appeared to be consistent, and the ME's staff said the cause of the SC's death seemed to be early onset of a medical condition. LE said currently there did not appear be any criminality and no

arrest unless the autopsy report revealed otherwise.

On 9/15/16, the ME informed ACS that there was no evidence of injury, and the SC had an undiagnosed disease while she was alive.

On 10/19/16, the Article Ten Neglect petition was withdrawn due to the death of the SC. There were no surviving siblings and no other children in the petition.

On 11/9/16, ACS visited the MGM's home. ACS observed the teenage MA and also inquired if the BM or any family members were interested in services. The MGM declined an offer for services.

The CONNECTIONS Event List reflected that for the 9/11/16 investigation, the Notice of Existence was not provided to the PGM, who was a subject of the report, nor was it provided to the BF.

On 11/23/16, ACS Unsubstantiated the allegations of DOA/Fatality and IG of the SC by the PGM. ACS noted the SC reportedly had difficulties breathing and the PGM took appropriate action by contacting EMS to transport the SC to the hospital. The ME stated there was no evidence of injury, and the SC had an undiagnosed disease while she was alive. The ME said they would examine the SC's organs under a microscope to verify what disease may have contributed to the SC's death. There were no reported outward signs of trauma to the body, the SC had no visible injuries, marks, bruises or signs of neglect. The final autopsy report is pending.

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?** 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

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? No

Explain:
NA

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	The CONNECTIONS Event List reflected that for the 9/11/16 investigation, the Notice of Existence was not provided to the PGM, who was a subject of the report. It was also not provided to the BF.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/11/2016 **Time of Death:** 04:30 AM

Time of fatal incident, if different than time of death: 09:30 PM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 11:46 PM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	Alleged Victim	Female	3 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	61 Year(s)

Other Household 1	Mother	No Role	Female	17 Year(s)
Other Household 2	Father	No Role	Male	36 Year(s)

LDSS Response

The documentation reflected that the BF had two other male children that do not reside with him.

On 9/11/16, the attending Nurse with the hospital said the SC was pronounced dead at 4:30 AM. ACS spoke with the attending Dr. who said as per the documentation the SC was triaged at 12:22 AM. The Dr. diagnosed a pre-existing medical condition. The Dr. said hospital personnel speculated the SC stopped breathing due to an infection, but the ME would determine the exact cause of death.

On 9/11/16, the BM informed ACS that the last time she saw the SC was on 9/2/16 in KCFC. The BM said she and the BF were arrested for criminal possession of a weapon, and on 9/2/16 an Article Ten Neglect petition was filed, and the SC was released to the PGM. BM reported that the SC was seen at Brookdale Family Health Center (BFHC) twice after 6/20/16. The BM said the SC did not have any medical issues and was not administered medication.

LE informed ACS that the PGM said the SC was experiencing respiratory problems and her last feeding was at 3:00 PM on 9/10/16. The PGM said the SC felt warm to the touch, but the SC was still eating. Later in the night, the SC ate less and her breathing appeared labored. The PGM told the PGA to call 911. EMS transported the SC to the hospital in respiratory distress. LE said the ME reported no signs of physical trauma and preliminary findings were consistent with the family's account. The SC's lungs had a lot of mucous and it was feasible for this condition to move rapidly in infants. The other symptoms were consistent with the condition of the SC.

When interviewed on 9/12/16, the PGA reported that the SC was fine, and was not sick. The SC was playful, smiled and was alert. The SC ate well and there were no indications that she was sick. The PGA said the PGM told her to call 911 as the SC appeared to have breathing difficulties. She called 911, but was not certain of the time. ACS inquired if the SC slept on her stomach or back. The PGA said the SC would be placed on her stomach but would awake quickly, and she would then be placed on her back where she slept well.

When interviewed on 9/13/16, the BM informed ACS that she refused to meet or answer any questions. ACS offered bereavement counseling. The BM said she did not need help but she asked about assistance to bury the SC. ACS informed her ACS could assist her. The BM agreed to meet ACS. Later, the BM said she only wanted assistance for the SC's burial, and she did not want to answer any questions.

When interviewed on 9/13/16, the PGM said she had no idea what occurred. She said the SC was fine with no indications that she was sick. The PGM said that on 9/10/16, the SC was fine all morning and afternoon. The SC began to cry at about 8:30 PM. She knew the SC was hungry as this was the only time she cried. She fed the SC who took about 3 to 4 sips, and would not take anymore. The SC was fussy so she placed her on her (PGM) shoulder and soothed her. She noticed the SC was a little warm, but not feverish hot. The PGM took a cool rag and wiped around the SC's chest and neck. The SC hiccupped and she saw that the SC gasped for air. She checked her and the SC's breathing did not seem normal so she told the PGA to call 911 as the SC was having difficulty breathing. The PGM said 911 was called between 10:00 PM and 11:00 PM. She said EMS was going to bring the SC to Woodhull Hospital but they said the hospital was full. She stated they asked her what hospital she wanted to go to. She instructed them to go to the nearest hospital.

The SC's Dr.'s office informed ACS on 9/14/16 that there were no concerns regarding the SC.

The EMS liaison reported on 9/15/16 that EMS was advised of the emergency to the home at 11:46 PM on 9/10/16.

On the same day, the BF provided ACS with the receipt to the funeral home for burial assistance. The BF said the SC did not have medical problems. The BM said she would think about if she needed counseling

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to previously approved protocol for joint investigations.

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
035823 - Deceased Child, Female, 3 Mons	036068 - Grandparent, Female, 61 Year(s)	Inadequate Guardianship	Unsubstantiated
035823 - Deceased Child, Female, 3 Mons	036068 - Grandparent, Female, 61 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household	☒	☐	☐	☐

members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?				
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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.

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐

Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: There were no additional services required.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The documentation reflected that ACS offered bereavement counseling to the family but the family declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? Yes
Were there any siblings ever placed outside of the home prior to this child's death? N/A
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 fetal alcohol effects or syndrome

☒ With neither of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/02/2016	14791 - Deceased Child, Female, 2 Months	14793 - Grandparent, Female, 40 Years	Inadequate Guardianship	Unfounded	Yes
	14792 - Mother, Female, 17 Years	14793 - Grandparent, Female, 40 Years	Inadequate Guardianship	Unfounded	
	14791 - Deceased Child, Female, 2 Months	14795 - Other - Step maternal grandfather, Male, 54 Years	Inadequate Guardianship	Unfounded	
	14792 - Mother, Female, 17 Years	14795 - Other - Step maternal grandfather, Male, 54 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 8/2/16 report alleged that the MGM and parent (step maternal grandfather to the now deceased SC) could not control the BM. BM had a history of running away from home. BM recently ran away from home and was being exploited by a man who was taking nude pictures of her while the man was getting high on cocaine with his friends.

Determination: Unfounded

Date of Determination: 10/01/2016

Basis for Determination:
ACS based the determination findings of no credible evidence obtained to Sub the allegations. The BM was dating 36-year-old man and the MGM recently became aware of his age, but the BM was 17 years old, and at the age of consent. The family members maintained that the BM was not running away from home as her whereabouts were always known to the MGM. The SC was with her BM and there was no evidence at this time that indicated the SC was at risk of harm.

OCFS Review Results:
During the investigation, ACS interviewed the BM, MGM, step-MGF, and teenage MA. ACS did not interview the 13-year-old neighbor (who resided upstairs) and who reported she stayed at the BF's home along with the BM, and SC. On 8/31/16, a report was registered; ACS closed the case as a Duplicate report. This report alleged that on 8/31/16, a search warrant was conducted at the residence for weapons. The SC was exposed to firearms and was in reach of a gun. LE said the BM contacted the PGM to pick up the SC. LE said the SC was released to the PGM's care. The PGM was not home at the time of the incident. The PGM told ACS she resided with her sister, and utilized the address for her mail.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
ACS did not interview the 13-year-old neighbor (who resided upstairs the case address) and who reported that she stayed at the BF's home along with the BM, and SC.

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

Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation

and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/02/2016	14734 - Deceased Child, Female, 2 Months	14731 - Mother, Female, 17 Years	Inadequate Guardianship	Indicated	Yes
	14734 - Deceased Child, Female, 2 Months	14735 - Father, Male, 36 Years	Inadequate Guardianship	Indicated	
	14734 - Deceased Child, Female, 2 Months	14735 - Father, Male, 36 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:
The 8/2/16 report alleged that the BM recently took the SC to the BF's home. The BF was doing cocaine with his friends and was taking nude pictures of the BM with the SC present.

Determination: Indicated **Date of Determination:** 10/01/2016

Basis for Determination:
The parents were arrested in the BF's home after a police raid was executed for weapons, and guns were found in the home within reach of the SC. The BF did not make himself available for a drug test or interview, after the arrest, so there was no credible evidence to support the allegations of PD/AM.

OCFS Review Results:
The investigation was begun timely. ACS completed a safety assessment on 8/9/16; however, it was inadequate as the comment did not support the selected safety factor that stated: "Child has significant vulnerability, is developmentally delayed, or medically fragile (e.g. on Apnea Monitor) and the Parent(s)/Caretaker(s) in unable and/or unwilling to provide adequate care and/or protection of the child(ren)." The Investigation Conclusion Narrative reflected that the allegation of IG was determined as both Sub and Unsub; the Allegation Information reflected as Sub. The BF informed ACS that he was not the SC's father as the BM told him he was not the father.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
ACS completed a safety assessment on 8/9/16; however, it was inadequate as the comment did not support the selected safety factor that stated; "Child has significant vulnerability, is developmentally delayed, or medically fragile (e.g. on Apnea Monitor) and the Parent(s)/Caretaker(s) in unable and/or unwilling to provide adequate care and/or protection of the child(ren)."

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

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

Issue:
Pre-Determination/Supervisor Review

Summary:
The Investigation Conclusion Narrative reflected that the allegation of IG was determined as both Sub and Unsub; the Allegation Information reflected as Sub.

Legal Reference:

18 NYCRR 432.2(b)(3)(v)

Action:

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

ACS did not interview the 13-year-old neighbor (who resided upstairs the case address) and who reported that she stayed at the BF's home along with the BM, and SC.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/03/2016	14691 - Deceased Child, Female, 1 Days	14641 - Mother, Female, 17 Years	Inadequate Guardianship	Indicated	Yes
	14691 - Deceased Child, Female, 1 Days	14641 - Mother, Female, 17 Years	Parents Drug / Alcohol Misuse	Indicated	
	14703 - Aunt/Uncle, Female, 15 Years	14702 - Grandparent, Female, 40 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:

The 6/3/16 report alleged that the BM gave birth to an infant. Upon delivery the BM tested positive for marijuana. There were concerns for the BM having adequate housing for herself and the SC.

Determination: Indicated **Date of Determination:** 08/02/2016

Basis for Determination:

ACS based the determination on Brookdale Hospital records indication that the BM tested positive for marijuana. ACS interviewed her and she admitted to marijuana use during her pregnancy, and she was not enrolled in a drug treatment program. The BM was reportedly homeless, not listed in her parent's lease, and had a history of running away from the home.

ACS added to the report the allegation of PD/AM of the 15-year-old MA by the MGM. The MGM had a history of misusing marijuana and had participated in preventive services, but continued to use marijuana. MGM admitted to marijuana use on a regular basis, and she tested positive for marijuana during the investigation.

OCFS Review Results:

The Investigation Conclusion Narrative did not reflect that ACS addressed the allegation of IG of the SC by the BM. Documentation of the 6/3/16 investigation reflected that there were notes that were not entered contemporaneously. There were events that occurred in June 2016 but were not entered until August 2016. The CONNECTIONS Event List reflected the BM, who was a subject of the report, was not provided with the Notice of Indication (NOI) within 7 days of the conclusion of the investigation. ACS added the MGM as a subject of the report, but the CONNECTIONS Event List did not reflect ACS provided her with a Notice of Existence (NOE).

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

Issue:
Pre-Determination/Supervisor Review
Summary:
ACS Sub the allegation of IG of the SC by the BM; however, the Investigation Conclusion Narrative did not reflect that the allegation was addressed.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
The documentation of the 6/3/16 investigation reflected there were notes that were not entered contemporaneously. There were events that occurred in June 2016 but were not entered until August 2016.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Failure to Provide Notice of Indication
Summary:
The CONNECTIONS Event List reflected that the BM, who was a subject of the report, was not provided with the Notice of Indication within 7 days of the conclusion of the investigation.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Failure to provide notice of report
Summary:
ACS added the MGM as a subject of the report, but the CONNECTIONS Event List did not reflect ACS provided her with a Notice of Existence.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

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

The PGM was not known to the SCR or ACS as a subject.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 06/21/2016

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: 06/21/2016

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?	☐	☐	☒	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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?	☐	☐	☒	☐

Provider

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

Additional information, if necessary:
The FSPN reflected that the family did not sign the intake for services. The family had not signed documentation for PPRS.

In addition, nine days after being released to the PGM, the SC died.

Required Action(s)

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

Preventive Services History

During the 6/3/16 investigation, ACS opened an Family Service Stage (FSS) on 6/21/16. According to the Initial FASP, the family service plan was drug counseling/treatment and parent training for the BM, and case management services and Early Intervention services for the SC. ACS referred the family for PPRS. The case planning responsibility was accepted by the Women's Prison Association (WPA) agency. The Family Service progress Notes (FSPN) reflected that the WPA agency stated a joint home visit occurred on 7/4/16, but the family did not sign for the intake for services. The family had not signed for PPRS.

The documentation reflected that an Article Ten Neglect Petition was filed on 9/1/16 in the KCFC naming the parents as the respondents. On 9/2/16, the SC was released to the PGM with supervision. The SC died nine days later.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/01/2016	There was not a fact finding	There was not a disposition

Respondent:	035825 Mother Female 17 Year(s)
Comments:	The documentation reflected that an Article Ten Neglect petition was filed on 9/1/16 in the KCFC naming the parents as the respondents. On 10/19/16, the Article Ten Neglect petition was withdrawn due to the death of the SC who was the only child named on the petition.

Have any Orders of Protection been issued? Yes	
From: 08/31/2016	**To:** 02/24/2017
Explain: The documentation reflected there was an order of protection (OOP) against the BM by the SC that expired on 2/24/17. In addition, there was an OOP for the BF to stay away from the SC-subject to Family Court.	

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