Child Fatality Report

Report Identification Number: NY-16-129

Prepared by: New York City Regional Office

Issue Date: May 31, 2017 **(Report was reissued on: May 31, 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: 8 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 12/13/2016
Initial Date OCFS Notified: 12/13/2016

Presenting Information

The 12/13/16 SCR report alleged the 8-month-old SC was found dead in her crib by the SM. The report also alleged one month prior to 12/13/16, the SC sustained a spiral fracture to her leg. There was no explanation for these conditions; therefore, the injury was considered suspicious and all the adults in the home were made subjects of the report.

Executive Summary

This 8-month-old female SC died on 12/13/16. According to the ME, the result of the autopsy was pending further studies and there were no suspicious marks or bruises observed on the SC. As of 4/14/17, NYCRO has not received the autopsy report.

The allegations of the 12/13/16 report were DOA/Fatality, IG and FX of the SC by the subject parents (SP), maternal grandparents (MGP) and MU.

According to the ACS case record, on 12/13/16, the MGM last observed the SC alive around 3:30 AM, when the SC fell asleep. The SM was asleep and the MGM placed the SC in the playpen in the room the SC shared with the SP and SS. The MGM slept in the room next door with the door open; so she could hear the SC. The MGM stated the SC did not have a feeding schedule in the early morning hours as the SC received continuous machine feedings. The MGM checked the SC at approximately 5:43 AM and observed the SC was unresponsive. The MGM alerted the SM and the MU. The MU called 911 and the MGM performed CPR on the SC until EMS arrived. Upon EMS' arrival, the SC was pulseless. Via ambulance, EMS drove the SC to the Cohen's Children's Hospital. The MGM remained at the family home to care for the SS. The MU drove the SM to the hospital. EMS arrived at the ER at 6:12 AM and the SC was pronounced dead at 6:27 AM.

During an interview with ACS staff, the SM said she had medical complications during her pregnancy and the SC was born premature, at 28-week gestation. The SC was born with medical complications and was diagnosed with medical conditions that contributed to the SC's developmental delay. The SC was monitored by several medical specialists prior to her death.

The SP, SC, SS and MU resided in the private home of the MGP. The SF, MGP and MU were employed and the SM was a homemaker. The SP, MGP and MU were interviewed regarding the events that led to the death of the SC. The SF stated he was not in the home at the time of the incident and the SM called and informed him the SC was in the ER. The SP declined further interviews with ACS and retained an attorney. The MGM stated she arrived from work on 12/12/16, at approximately 10:00 PM, the SC had to be consoled by her and the SM throughout the night; as the SC frequently cried. The MU stated he was unaware of the family's activities and was in the basement apartment until he was alerted by the MGM. The SM was inconsolable and did not ride in the ambulance. The MGF was at work at the time the MGM found the SC unresponsive.

During the interview with ACS staff, the MGF revealed that the SC was immunized on 12/10/16. The MGF described the SC had very active movements with her feet, smiled and was doing well prior to the immunization. The MGF

added that after the immunization the SC was not active and did not respond as usual. On 12/12/16, the SM accompanied the MGF and SC to a medical appointment. The statements provided by the SP, MGP and MU were consistent.

ACS offered bereavement counseling and burial assistance to the SP and the MGP; however, they declined services. The family stated they preferred to receive services privately and through their religious affiliation. The SM followed through on services the SS had been previously referred to by medical providers.

The investigation revealed there was no evidence the SP, MGP or the MU had history of domestic violence, mental illness, or substance abuse. According to the record, the collateral contacts expressed no concerns regarding the care the SM provided the SC and SS.

On 4/3/17, ACS substantiated the allegations of DOA/Fatality, IG and FX of the SC by the parents and unsubstantiated all allegations of the SC by the MGP and MU. ACS did not provide any supporting narrative to justify the decisions to substantiate or unsubstantiated the respective allegations. ACS did not justify whether the agency found credible evidence to substantiate the allegations pertaining to the parents.

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?** No, sufficient information was not gathered to determine any of the allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** No

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

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

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

Explain:
The Family Services Stage (FSS) stage remained open as Queens County Family Court (QCFC) released the SS to the MGP with Court Ordered Supervision (COS) by ACS.

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 Fatality Report and the corresponding safety assessment were not completed within the required timeframe.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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:	Appropriateness of allegation determination
Summary:	The CSP Investigative Summary did not contain a narrative to support ACS' decisions for the reported allegations.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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 safety factors selected and the corresponding comments were not specific or indicative to the safety of the SS.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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:	There were a significant number of progress notes entered on dates that exceeded the specified timeframe from an event date.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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 case recording
Summary:	The ACS Safety Plan did not identify the caretakers responsibilities and timeframes for completion of activities to protect the SS.
Legal Reference:	18 NYCRR 428.5(c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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 Supervisor Review notes were observed to be repetitive directives without supervisory consultations. The supervisory approvals and summaries at key points of the investigation were not documented.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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: 12/13/2016 **Time of Death:** 06:27 AM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? Yes
Time of Call: 05:45 AM
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:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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	Aunt/Uncle	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	58 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	65 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)

LDSS Response

According to LE, the SP were escorted to the precinct from the hospital to be interviewed. LE stated the SP refused to speak to LE without a lawyer present; therefore, the SP were not interviewed. The MGP provided consent for LE to check the home. LE deemed the case address a crime scene; therefore, ACS could not conduct an immediate home assessment. There were no arrests made.

On 12/13/16, the MGF said he left his job after he received a call from MGM who said the SC was not breathing and was taken to the hospital. Upon his arrival to the family home; he was told the SC died. The MGF said, on 12/12/16 at approximately 10:00 PM he left for work. The MU, SP, SC and SS were in the home. The MGF said the SS appeared to not be aware of the SC's death.

On 12/13/16, the MGM said on 12/12/16 she arrived from work at approximately 10:00 PM and observed the SF in the home; however, he was not in the room when she checked the SC at 5:43 AM. The MGM stated she was certified in CPR and the SS was sleeping in the SM's room at the time of the incident. The MGM did not recall the time EMS arrived at the home.

On 12/13/16, the Specialist assessed the SS for safety. The SS appeared comfortable in the home with the MGP, SP and MU. The SS was unaware of the SC's death. The Specialist, observed the SS was adequately dressed and free of marks and bruises.

According to the MU, the SM was inconsolable and unable to accompany the SC in the ambulance. The MU said the basement apartment had a separate entrance and he was unaware if the SF was in the home prior to the incident. The MU recalled when he was alerted by the MGM, the SF was not in the home.

ACS conducted a home assessment of the two-floor private home of the MGP. ACS found the family's home was adequately furnished and there were sufficient provisions in the home for the SS. The Specialist observed the SP shared a room with the SC and SS. The SS co-slept with the SP in a queen sized bed. ACS staff observed there were working smoke/carbon monoxide detectors in the home. There were no observable hazardous conditions in the home.

According to the attending Dr., there were no visible signs of foul play observed on the body of the SC. The medical staff stated the SC had significant long term medical issues that may have contributed to the SC's death.

On 12/22/16, ACS held an Initial Child Safety Conference (ICSC) at the LDSS office. The SP and MGP participated by telephone. ACS offered services and the family declined.

On 1/17/17, ACS held a 20-Day conference with the SP at the LDSS office to discuss the service plan. The SP discussed the SS scheduled and participation in specialized therapeutic and educational supportive services. The limited OOP and the remand of the SS to the MGP with COS by ACS remained in effect.

During the investigation, the Specialist made pertinent collateral contacts with the SC and SS various medical specialists. The providers had no safety concerns regarding the care the SP provided the SC and SS. The SM appeared knowledgeable of the SC and SS medical conditions and she diligently attended all scheduled appointments. The SC and SS immunizations were up to date.

The FSS had remained opened since 11/23/16. On 4/14/17, ACS made a recent home visit and observed the SS. The SS appeared healthy; free of marks and bruises. There were no safety concerns observed by the Specialist. The initial and comprehensive FASPs were not initiated or approved within the required timeframes.

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 protocols for joint investigation.

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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
033761 - Deceased Child, Female, 8 Mons	036602 - Father, Male, 29 Year(s)	DOA / Fatality	Substantiated
033761 - Deceased Child, Female, 8 Mons	036604 - Grandparent, Female, 58 Year(s)	Inadequate Guardianship	Unsubstantiated
033761 - Deceased Child, Female, 8 Mons	036605 - Aunt/Uncle, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
033761 - Deceased Child, Female, 8 Mons	036605 - Aunt/Uncle, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
033761 - Deceased Child, Female, 8 Mons	036601 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
033761 - Deceased Child, Female, 8 Mons	036601 - Mother, Female, 35 Year(s)	Fractures	Substantiated

033761 - Deceased Child, Female, 8 Mons	036605 - Aunt/Uncle, Male, 37 Year(s)	Fractures	Unsubstantiated
033761 - Deceased Child, Female, 8 Mons	036602 - Father, Male, 29 Year(s)	Inadequate Guardianship	Substantiated
033761 - Deceased Child, Female, 8 Mons	036601 - Mother, Female, 35 Year(s)	DOA / Fatality	Substantiated
033761 - Deceased Child, Female, 8 Mons	036604 - Grandparent, Female, 58 Year(s)	DOA / Fatality	Unsubstantiated
033761 - Deceased Child, Female, 8 Mons	036603 - Grandparent, Male, 65 Year(s)	DOA / Fatality	Unsubstantiated
033761 - Deceased Child, Female, 8 Mons	036603 - Grandparent, Male, 65 Year(s)	Inadequate Guardianship	Unsubstantiated
033761 - Deceased Child, Female, 8 Mons	036602 - Father, Male, 29 Year(s)	Fractures	Substantiated
033761 - Deceased Child, Female, 8 Mons	036604 - Grandparent, Female, 58 Year(s)	Fractures	Unsubstantiated
033761 - Deceased Child, Female, 8 Mons	036603 - Grandparent, Male, 65 Year(s)	Fractures	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:

The ACS record did not indicate whether the agency attempted to contact the responding EMS officials to obtain

information about their observations of the SC and home conditions.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☐	☒	☐	☐
At 30 days?	☐	☒	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Explain:
The SS was not observed for the seven or 30 day safety assessment documentation. An initial safety assessment of the SS was conducted on 12/13/16; however, there was no ongoing safety assessment. Following the fatality, the progress note stated the SS was observed and assessed on 1/26/17, 2/17/17 and 3/21/17; all visits were made after the key safety assessment timeframes.

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

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

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: military services							
Additional information, if necessary: ACS offered bereavement counseling and burial assistance to the SP and the MGP; however, the services were declined. The family stated they preferred to receive services privately and through their religious affiliation. The SM followed through on specialized services the SS was previously referred to by medical specialists.							

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

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

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? 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)	Status/Outcome	Compliance Issue(s)
11/21/2016	13231 - Deceased Child, Female, 7 Months	15044 - Grandparent, Female, 58 Years	Fractures	Unfounded	Yes
	13231 - Deceased Child, Female, 7 Months	15044 - Grandparent, Female, 58 Years	Inadequate Guardianship	Unfounded	
	13231 - Deceased Child, Female, 7 Months	15041 - Mother, Female, 35 Years	Inadequate Guardianship	Indicated	
	13231 - Deceased Child, Female, 7 Months	15042 - Father, Male, 29 Years	Inadequate Guardianship	Indicated	
	15046 - Sibling, Female, 3 Years	15041 - Mother, Female, 35 Years	Inadequate Guardianship	Indicated	
	13231 - Deceased Child, Female, 7 Months	15041 - Mother, Female, 35 Years	Fractures	Indicated	
	13231 - Deceased Child, Female, 7 Months	15042 - Father, Male, 29 Years	Fractures	Indicated	
	13231 - Deceased Child, Female, 7 Months	15043 - Grandparent, Male, 65 Years	Fractures	Unfounded	
	13231 - Deceased Child, Female, 7 Months	15043 - Grandparent, Male, 65 Years	Inadequate Guardianship	Unfounded	
	15046 - Sibling, Female, 3 Years	15042 - Father, Male, 29 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 11/21/16 SCR report alleged the 7-month-old SC presented with a fractured left femur. The SM claimed the SC's foot got stuck in the slats of the crib. The explanation was inconsistent with the nature of the injury; therefore, all the adults in the home were considered alleged subjects. The role of the 3-year-old female sibling was unknown.

Determination: Indicated | **Date of Determination:** 01/25/2017

Basis for Determination:
ACS substantiated the allegations of FX and IG of the SC by the SP on the basis that the SP's explanation of the SC's injury was not consistent with the Dr.'s findings. The Dr. said the SP explanation of the SC's medical condition was inconsistent with the nature of the injury. The SP did not seek immediate medical care for the SC when the MGP suggested the SC was in pain.

ACS added to the report and substantiated the allegation of IG of the SS by the SP on the basis of the inability of the SP to ensure the safety of the SC.

ACS unsubstantiated the allegation of FX and IG of the SC by the MGP on the basis the SP were the primary caregivers of the SC and SS at the time of the incident.

OCFS Review Results:
The results of this review showed that ACS documented diligent efforts in the progress notes of casework contacts and pertinent collateral contacts. There was sufficient and relevant face-to-face casework contact with SC, SS, SP and other household members. The 7-Day safety assessment was not adequately completed, the notice of report was not provided to the subjects, the Initial and Comprehensive FASPs were not approved in a timely manner.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The safety decision for the 7-Day safety assessment did not identify the potential or actual safety factors that placed the children in immediate or impending danger of serious harm to support ACS' decision to initiate safety intervention.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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:
The investigative actions inaccurately indicated the notification of existence was provided to the subject. The documentation and the stage event reflected the subjects were not provided a notification of existence of a report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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:
Appropriateness of allegation determination
Summary:
There were no identified child abuse/maltreatment actions or inaction to substantiate the allegation of IG by the SP. ACS' interviews with collateral contacts and the assessment of the SS did not support ACS' decision to add the SS to the report and substantiate the allegation of IG for the SS by the SP.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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:
During the investigation, the ACS record did not reflect adequate safety assessments of the SC and SS that was consistent with the allegations and the family's court involvement.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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:
There were progress notes with event dates of 12/5/16, 12/7/16, 12/13/16 and 1/9/16 that were entered on 1/18/17, 1/20/17 and 2/13/17; respectively. The notes were not entered within the required 30-day timeframe.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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 face-to-face contacts with the child and/or child's parents or guardians
Summary:
ACS documentation did not include the ACS staff actual observations of the SC and SS in the home with the caretaker or a description of the SS or the injury the SC sustained.
Legal Reference:
18 NYCRR 432.1 (b)(3)(ii)(a)
Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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:
During the review, the Supervisor Review notes were repetitive directives. The supervisory approvals and corresponding summaries at key points of the investigation were not documented. The family team meeting follow-up conference did not include information regarding the safety plan, updates and family involvement in the services plan implementation.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

[redacted]

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

There was no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 11/23/2016

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: 11/23/2016

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?	☐	☒	☐	☐
If not, how many days was it overdue? As of 4/17/17, the most recent FASP due on 2/21/17 was not approved.				
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: ACS provided case management services.				

Required Action(s)

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The Risk Assessment Profile (RAP) included incorrect responses for the elevated risk elements, thereby resulting in a Final Risk Rating of "Low." The "Low" risk rating did not reflect the case circumstances.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took 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:	Timeliness of completion of FASP
Summary:	The initial FASP was due on 12/23/16; however, the FASP was approved on 1/13/17. The comprehensive FASP was due on 2/23/17 was not initiated or approved by the due date.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Preventive Services History

ACS opened the Family Services Stage (FSS) on 11/23/16. As a result of an Article Ten Neglect petition, the QCFC released the SC and SS to the care of the MGP with Court Ordered Supervision (COS) by ACS on 11/28/16. The QCFC allowed the SP to remain in the home with the SC and SS to be supervised by the MGP or the MU.

There was no documentation of ACS face-to-face contact with the SC and SS in the home prior to the fatality. The face-to-face contacts with the SS in the home with the subjects were not conducted to meet the program requirement of a minimum frequency of two contacts per month. The Family Services Progress Notes reflected ACS made home visits to monitor the subjects with the SS on 12/13/16, 1/26/17, 2/17/17, 3/22/17 and 4/14/17. The minimum monitoring standard for preventive services were not met. The SS was provided case management and Early Intervention (EI) services. As of 4/17/17, the most recent FASP due on 2/21/17 was not approved.

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:**
11/25/2016	There was not a fact finding	There was not a disposition
Respondent:	033761 Deceased Child Female 8 Mons	
Comments:	The QCFC released the SC and SS to the MGP with COS by ACS.	

Have any Orders of Protection been issued? Yes	
From: 11/28/2016	**To:** Unknown
Explain: Due to the unexplained nature of the injury the SC sustained while in the care of the SP, the QCFC issued a limited OOP on behalf of the SC and SS. The OOP stipulated the SP were allowed to remain and were to supervised at all times by the MGP or the MU with the SC and SS.	

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