Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-023

Prepared by: New York City Regional Office

Issue Date: Aug 26, 2019

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		

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 02/28/2019
Initial Date OCFS Notified: 02/28/2019

Presenting Information

The 2/28/19 SCR report alleged, on 2/28/19, the SC (4 months), an otherwise healthy child, died of cardiac arrest. On 2/28/19, the SM found the SC unresponsive. The SM and SF were in the home at the time of the incident. The SM performed cardiopulmonary resuscitation on the SC as the SF called 911. Upon 911 being called, law enforcement and EMS arrived at the home at which time the SC was taken to the hospital. The SC arrived at the hospital at 6:46 AM on 2/28/19 and was pronounced dead at 6:57 AM on 2/28/19. No visible injuries were observed at that time. The SM and SF were named as alleged subjects pending the outcome of the investigation. The SS, ages: 10 and 3 years, had unknown roles.

Executive Summary

The 4-month-old female infant died on 2/28/19. The ME listed the cause of death as undetermined (bed sharing with adult, adult bed, soft bedding) and the manner as undetermined.

The allegations of the 2/28/19 report were DOA/Fatality and IG of the SC by the SM and SF.

ACS findings reflected the SC was an otherwise healthy child. The SC reportedly had a cough prior to her death. The SM reportedly placed the SC on her queen size bed to sleep between the hours of 12:00 and 1:00 AM on 2/28/19. Thereafter, the SM went out of the home to purchase an item from the store. Upon the SM's return, she dozed off beside the SC at 4:00 AM. The SM woke up at 6:00 AM and observed the SC on her queen size bed unresponsive and blue. The SM went to a neighbor and asked her to call 911. The neighbor contacted 911, followed the operator's instructions and began CPR on the SC; however, attempts to resuscitate the SC were unsuccessful. The SM also alerted the SF who was asleep in the home.

During the investigation, ACS made multiple announced and unannounced visits to the home. ACS observed the 3-year-old and 10-year-old SS and noted they did not have visible marks or bruises. ACS observed the home and had no concerns. ACS obtained supporting documentation from the ME, LE and social service history databases. ACS interviewed neighbors and social service staff. ACS did not contact the family physician and hospital medical personnel to obtain the SC and SM's medical records. It was unclear whether ACS contacted EMS to obtain their responders' account of their activities and observations of the household condition.

On 5/29/19, ACS unsubstantiated the allegations of DOA/Fatality of the SC by the SM and SF on the basis the ME found no signs of abuse of the SC. ACS unsubstantiated the allegation of IG of the SC by the SF on the basis the SF provided the SC with food, shelter and clothes and there was no evidence the SF neglect the SC.

ACS substantiated the allegation of IG of the SC by the SM on the basis the SM co-slept with the SC after the hospital advised the SM about the dangers of co-sleeping with an infant. The caseworker also advised the SM not to co-sleep with the SC and placed the safe sleep pamphlet over the SC's crib. The SM admitted to co-sleeping with the SC.

The preventive case remained open for COS at the time of issuance of this fatality report.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
Sufficient Information was gathered to make a determination for all allegations identified during the investigation.

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:
ACS gathered sufficient information from LE, extended family members, service providers, school personnel, and neighbors; however, ACS did not obtain pertinent information from the family physician and attending physician of the SC.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-hour fatality report document was not completed within 24 hours and was completed on 5/15/19.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day fatality report document was not completed within 30 days of SCR report and was completed/approved on 5/15/2019.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will 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 Progress Notes
Summary:	The progress notes were not entered contemporaneously, with event dates of 3/16/19 and entry dates of 5/21/19.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will 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 24 Hour Assessment
Summary:	The 24-Hour safety assessment document was not timely and was submitted on 3/5/19.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will 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 30-Day Safety Assessment
Summary:	ACS assessed safety of the SS within the 30-day timeframe. However, ACS did not complete the required 30-Day safety assessment document.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will 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 Risk Assessment Profile (RAP)
Summary:	The risk assessment did not include the SF as a secondary caretaker. The family had a history of unstable housing, and domestic violence incidents in the home and community which was not reflected in the RAP.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will 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:	During the investigation, ACS did not contact with the family physician to obtain pertinent information.
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 will 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: 02/28/2019 **Time of Death:** 06:57 AM

Time of fatal incident, if different than time of death: 06:00 AM

County where fatality incident occurred: Bronx
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

Did child have supervision at time of incident leading to death? Yes
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	Deceased Child	Alleged Victim	Female	4 Month(s)

Deceased Child's Household	Father	Alleged Perpetrator	Male	51 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

ACS initiated the investigation within the required timeframe. ACS verified the SC was taken to the local hospital and pronounced dead after EMS, SM and SF's CPR attempts were unsuccessful.

Between 2/28/19 and 3/5/19, ACS obtained information from pertinent collateral contact, including: LE, ME, caseworker, and SM. On 2/28/19, ACS learned from LE that there was no suspicion of foul play or outward signs of abuse or trauma to the SC.

ACS contacted the ME, and a community based organization servicing the family. The ME stated that the preliminary findings did not show signs of outward abuse that could have caused the death of the SC. The case worker said there were no concerns regarding the care the SM and SF provided the SC and SS.

The caseworker made unannounced visits to the home and did not observe any safety issues in the home. The caseworker discussed safe sleep practices with the SM and SF and advised the SM and SF not to co-sleep with the SC.

On 3/1/19, ACS followed up with LE regarding police investigation and learned there was no new information about the SC's death.

According to the SM's account, she last saw the SC alive two hours prior to the SC's demise. She slept beside the SC in the bed, and the SF slept in the living room. She found the SC on the bed at approximately 6:00 AM unresponsive and not breathing. The SM said she and the SF received safe sleep practice education. The two SS were in the home when the SC died. The SM and SF had a history of drug/alcohol use and remained in treatment programs to cope with their drug use. The SF's account was similar to the information that the SM provided to ACS.

ACS held an Initial Child Safety Conference on 3/1/19, for the SM and SF at separate times. ACS concluded that an Article Ten Neglect petition would be filed against the SM and SF at Bronx County Family Court (BCFC). The allegations included EN of the SC, IG, and failure of SM and SF to address their mental health. ACS awaited the final report of autopsy for the SC. ACS requested Court Ordered Supervision (COS).

On 3/4/19, ACS filed the Article Ten Neglect petition in BCFC. The judge granted COS of the subject family.

On 3/5/19, ACS interviewed a neighbor regarding the SC's death. ACS learned that the SM knocked on the neighbor's door and requested that the neighbor call 911. The neighbor contacted 911 and was directed by the operator to perform CPR on the SC. The neighbor's attempts at CPR were unsuccessful.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
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
050989 - Deceased Child, Female, 4 Mons	050991 - Father, Male, 51 Year(s)	Inadequate Guardianship	Unsubstantiated
050989 - Deceased Child, Female, 4 Mons	050990 - Mother, Female, 43 Year(s)	Inadequate Guardianship	Substantiated
050989 - Deceased Child, Female, 4 Mons	050991 - Father, Male, 51 Year(s)	DOA / Fatality	Unsubstantiated
050989 - Deceased Child, Female, 4 Mons	050990 - Mother, Female, 43 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
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 progress notes were not entered contemporaneously.

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: The risk assessment did not list the SF as a secondary caretaker. The family had a history of unstable housing, domestic violence incidents in the home and community which was not reflected in the RAP.				

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: There was no removal of the surviving children.				

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/04/2019	Other, Specify	There was not a disposition
Respondent:	050990 Mother Female 43 Year(s)	
Comments:	On 3/4/19, ACS filed an Article Ten Neglect petition in Bronx County Family Court (BCFC) against the SM and SF on behalf of the SS. There were concerns regarding IG of the SS as the SM's older children were removed from her care, prior to the current report, due to abuse or neglect. The SM was not engaged in mental health treatment prior to the death of the SC. The judge granted COS of the family. The documentation did not include outcome of the fact finding hearing that occurred on 8/8/19.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/04/2019	Other, Specify	There was not a disposition
Respondent:	050991 Father Male 51 Year(s)	
Comments:	On 3/4/19, ACS filed an Article Ten Neglect petition in Bronx County Family Court (BCFC) against the SM and SF on behalf of the SS. There were concerns regarding IG of the SS as the SM's older children were removed from her care, prior to the current report, due to abuse or neglect. The SM was not engaged in mental health treatment prior to the death of the SC. The judge granted COS of the family. The documentation did not include outcome of the fact finding hearing that occurred on 8/8/19.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐

Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☒	☐	☐	☐	☐	☐	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☒	☐	☐	☐	☐	☐	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☒	☐	☐	☐	☐	☐	☐
Alcohol/Substance abuse	☒	☐	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☒	☐	☐	☐	☐	☐	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The family received Court Ordered Supervision with ACS. The SM and SF continued to engage in alcohol/substance abuse treatment.

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 10-year-old SS received individual bereavement counseling at school.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents received burial assistance, mental health and homemaking services.

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)
02/17/2016	Sibling, Male, 1 Days	Mother, Female, 40 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes
	Sibling, Male, 1 Days	Father, Male, 48 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The 2/17/16 SCR report alleged in February of 2016, the SM gave birth to a male SS. The SM tested positive for opiates at the time of birth. No further details were known at the time. The roles of the SF and other SS were unknown.

Report Determination: Indicated | **Date of Determination:** 03/22/2016

Basis for Determination:
ACS substantiated the allegation of PD/AM of the SS (who was then a newborn child) by the SM and SF. ACS noted the SM gave birth to the SS in February of 2016, and the SS tested positive for opiates upon birth. ACS explained that the SF should have known the SM engaged in drug abuse while pregnant. In the Investigation Conclusion Narrative, ACS did not state whether the SM and SF's actions had a negative impact on the care they provided the SS following his birth.

OCFS Review Results:
ACS interviewed and assessed the SM, SF and other SS. ACS obtained pertinent information from the MGM, SM and SF's service providers, SS's school and mental health provider. The SM said she had a history of drug misuse and mental health issues. ACS verified the SS, who was then a newborn, had a positive toxicology.

There was no documentation in the case record that described the SS's sleeping arrangements or the conditions of the home. ACS did not discuss safe sleep practices with the SM and SF. ACS did not document whether the SM had sufficient provisions for the SS, who was then a newborn child. The ACS Specialist noted the other SS had no visible marks/bruises.

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

Issue:
Failure to provide safe sleep education/information

Summary:
There was no indication in the case record that safe sleep practices were discussed with the SM and SF.

Legal Reference:
13-OCFS-ADM-02

Action:
ACS must submit a PIP within 45 days that identifies the action the agency will 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 Progress Notes
Summary:
ACS assessment of the family did not include documentation that described the SS's sleeping arrangements or the conditions of the home. ACS did not document whether the SM had sufficient provisions for the SS, who was then a newborn child.
Legal Reference:
18 NYCRR 428.5
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will 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:
Appropriateness of allegation determination
Summary:
ACS substantiated the allegation of PD/AM of the SS by the SM and SF. In the Investigation Conclusion Narrative, ACS noted the SM used illicit substances during pregnancy. However, ACS did not include information about the care the SM and SF provided the SS following his birth.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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

The SM was a subject in four SCR reports dated 11/18/2011, 01/17/12, 11/9/12, 4/17/15. The allegations of the four reports were a combination of IG, LS, PD/AM, EDN, LMC, and IF/C/S of the 10-year-old SS. The 11/18/11 and 1/17/12 reports were indicated. The 11/9/12 and 4/17/15 reports were unfounded.

ACS substantiated the allegations of IG and IF/C/S of the SS by the SF, stemming from the 1/18/11 and 1/17/12 reports. On 1/24/12, ACS filed an Article Ten Neglect petition on behalf of the 10-year-old SS, naming the SF as the respondent. The SM and SS received COS which ended on 7/17/13.

Known CPS History Outside of NYS

There was no known CPS History outside of New York State.

Preventive Services History

ACS opened a preventive services case on 1/19/2012, and monitored the family through COS. ACS closed the preventive services case on 7/17/13 as COS expired. The family also received community based services.

In February 2016, ACS opened a preventive services case as there was evidence of the SM's drug misuse. ACS filed an

Article Ten Neglect petition and the judge released the SS to the SM and SF with COS for the family. The SM and SF agreed to participate in intensive home-based treatment because they wanted access to community resources. The family was referred to New York Foundling Mott Haven PPRS on 4/27/16. The SM and SF engaged in substance abuse treatment at Samaritan Village, services at New York Psychotherapy, housing at Women In Need, parenting for children with developmental disabilities, and care coordination through Bronx Works. ACS closed the preventive services case on 8/30/17 after all the family's goals were met. ACS completed the required number of casework contacts to meet the program requirements.

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

Additional Local District Comments

There are no additional Local district comments.

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