Child Fatality Report

Report Identification Number: AL-21-036

Prepared by: New York State Office of Children & Family Services

Issue Date: Jun 02, 2022

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☒ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 7 day(s)
Jurisdiction: Albany
Gender: Female
Date of Death: 09/06/2021
Initial Date OCFS Notified: 12/17/2021

Presenting Information

On 12/16/2021, Albany County Department for Children, Youth and Families (ACDCYF) learned of the death of the 7-day-old female child that occurred on 9/6/2021. The subject child was born on 8/30/2021 at 23-weeks gestation with several medical complications due to prematurity. At the time of the death, the mother had an open services case in NYC and Albany due to her other children being placed in foster care in those jurisdictions. ACDCYF notified the Albany Regional Office of the death via telephone and completed the 7065 Agency Reporting Form in a timely manner.

Executive Summary

On 12/16/2021, ACDCYF received an SCR report regarding the subject child's surviving twin sibling. The SCR report alleged the twin sibling was hospitalized following her birth due to complication from prematurity. The twin sibling was ready to be discharged and the mother had not participated in required training to learn how to provide the twin sibling's medical care. Upon initiation of the investigation, ACDCYF learned of the subject child's death that occurred on 9/6/2021. ACDCYF was not previously aware of the subject child's birth and death, as the mother had not maintained communication with Administration for Children's Services(ACS) or ACDCYF throughout her services cases.

The subject child was born on 8/30/2021 at 23-weeks gestation via an emergency C-section. The mother reported she had been residing in NYC; however, was visiting with the maternal grandmother in Albany County when the subject child was born. The subject child and her twin sibling were hospitalized due to medical complications as a result of their prematurity. The subject child's condition was unstable and she progressively declined. On 9/4/2021, the subject child experienced multi-organ failure among other complications. The subject child's condition declined and she died on 9/6/2021. The mother remained in Albany County following the death due to the twin sibling's hospitalization; however, at the time this report was written she had left the grandmother's home and her whereabouts were unknown to ACDCYF.

Upon learning of the death, ACDCYF assessed the safety of the five surviving siblings, ages 6, 5, 4 and 1-years-old and 3-months-old. At the time of the death, the 6 and 5-year-old siblings were in joint custody of the maternal grandmother and aunt in Albany County. The maternal grandmother obtained custody of the 6 and 5-year-old siblings in 2016. In July 2018, the siblings were removed from the grandmother due to concerns she was unable to provide them with appropriate supervision. A Neglect Petition was filed and the grandmother completed services required by ACDCYF. The 6 and 5-year-old siblings returned to her custody in March 2021 and the maternal grandmother was in receipt of after-care services.

The 4-year-old sibling was placed in kinship foster care in 2018 through ACS and the 1-year-old sibling was placed in foster care through ACS in 2020. Since the siblings' placement with relatives and in foster care, the mother had minimal contact with ACS and ACDCYF and had not participated in services to regain custody of the siblings. Due to the twin sibling's medical needs, the siblings' out of home placements, and the mother having had a child die in 2013 due to medical neglect, ACDCYF filed a Derivative Neglect Petition against the mother and the twin sibling was placed in foster care.

ACDCYF spoke to hospital staff and determined the subject child's death was not the result of abuse or maltreatment by the mother. An autopsy was performed and it was determined the death was a result of medical complications due to the subject child's premature birth. The mother was provided with information regarding mental health counseling. The

maternal grandmother's services case closed on 3/29/2022. ACDCYF opened a foster care case for the mother regarding the twin sibling and the mother's foster care case in NYC remained open at the time this report was written.

PIP Requirement
ACDCYF will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify action(s) ACDCYF has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACDCYF will review the plan and revise as needed to address ongoing concerns.

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?** N/A

Determination:

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

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 maternal grandmother's foster care case regarding the 5yo and 6yo siblings was closed. The mother continued to have an open foster care case through ACS regarding the 4yo and 1yo siblings and an open foster care case through ACDCYF regarding the twin sibling.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/06/2021 **Time of Death:** Unknown

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

County where fatality incident occurred: Albany

Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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: Hospitalized

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **In the same room as the child**

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	No Role	Female	7 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	53 Year(s)
Deceased Child's Household	Mother	No Role	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Day(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)

LDSS Response

Within 24 hours of learning about the subject child's death, ACDCYF notified OCFS through the required 7065 Agency Reporting Form. ACDCYF completed interviews with the family and collateral sources and assessed the safety of the surviving siblings.

ACDCYF received information regarding the fatality by interviewing the mother, hospital personnel and obtaining the autopsy report. The mother initially presented to the hospital after she had experienced vaginal bleeding and pelvic pressure. The mother reported no prior complications during her pregnancy and there were no concerns for drug or alcohol misuse. The mother gave birth to the subject child and twin sibling via an emergency C-section on 8/30/2021. The subject child and twin were admitted to the hospital following their birth. Despite extensive efforts and medical care, the subject child died on 9/6/2021 while at the hospital. ACDCYF regularly inquired with hospital staff about the status of the surviving twin sibling and attended a meeting with the mother, grandmother, foster parents and hospital personnel in order to plan for the sibling's care. The twin sibling was discharged from the hospital to foster care on 1/30/2022.

The autopsy reflected that the twins' premature birth was associated with amniotic fluid infection with acute chorioamnionitis. In relation to the death, the autopsy noted the subject child's death occurred 7-days following delivery secondary to complications of extreme prematurity, with significant post-mortem findings that included interventricular

and germinal matrix hemorrhages and acute neonatal lung injury with multifocal hemorrhage and hematomas in bilateral lungs.

ACDCYF conferenced with ACS to confirm the safety of the 4 and 1-year-old siblings in their foster care placements. ACS visited with the children at their respective foster homes and there were no concerns for their safety. ACS completed an interview with the biological father of the twins and 1-year-old sibling. The father reported he was incarcerated at the time of the subject child's birth and had not had the opportunity to meet her. ACDCYF interviewed the grandmother, mother and 5 and 6-year-old siblings at the grandmother's home. ACDCYF suggested the grandmother provide supervision of the mother's contact with the siblings, which she was agreeable to. There were no other concerns for their care with the grandmother.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Other physician

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: ACDCYF reported this death was not referred to their OCFS approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
Approximately 115 of 614 notes were entered more than a month after their event dates.

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?	☒	☐	☐	☐

Explain:
As there was no SCR report surrounding the fatality, the completion of safety assessments was not required. Following the death, ACDCYF assessed the safety of the 5yo and 6yo siblings, who were in the custody of the maternal grandmother. In addition, ACDCYF confirmed with ACS that the mother's 4yo and 1yo children were safe in their foster care placements in NYC. A Neglect Petition was filed against the mother regarding the twin sibling, and the twin was placed in foster care.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The twin sibling was removed from the mother and placed in foster care due to concerns that the mother was unable to provide for the twin sibling's medical needs.

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:**
01/18/2022	There was not a fact finding	There was not a disposition
Respondent:	060354 Mother Female 26 Year(s)	
Comments:	On 1/13/2022, ACDCYF filed for a removal of the twin sibling and the mother consented to the removal. On 1/18/2022, ACDCYF filed a Derivative Neglect Petition against the mother.	

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:
ACDCYF provided the mother with information regarding mental health services. In addition, the mother was provided with information for a substance misuse evaluation, which had been requested of her by ACS, and had not yet been completed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was provided information regarding mental health counseling.

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? Yes
Was the child acutely ill during the two weeks before death? Yes

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)
05/15/2020	Sibling, Male, 21 Days	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
The Administration for Children's Services (ACS) received an SCR report that stated the mother gave birth to the 1-year-old sibling and had a child, the 4-year-old sibling, who was placed in foster care.

Report Determination: Indicated **Date of Determination:** 07/06/2020

Basis for Determination:
The allegation of Inadequate Guardianship against the mother was substantiated. The sibling was admitted to the NICU following his premature birth. The mother failed to maintain consistent contact with the hospital during the sibling's hospitalization. The mother stopped visiting with the sibling a month prior to medical discharge. The mother had not responded to ACS's outreach and was not complying with the agency. The mother's whereabouts were unknown.

OCFS Review Results:
ACS immediately confirmed the sibling's admittance to the hospital, and documented regular contact with the hospital regarding his medical status. Despite numerous attempts to contact and locate the mother, the mother did not make herself available to ACS or the hospital. ACS explored relative resources for placement of the child. On 5/21/20, ACS filed a Neglect Petition and the sibling was remanded to foster care. ACS documented several supervisory consultations, notes were entered contemporaneously with their event dates, and the determination was supported by the case record. The father of the sibling was not notified of the SCR report.

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

Issue:
Failure to provide notice of report

Summary:
The mother provided the name of the the 1-year-old sibling's father and that he was incarcerated. The record did not reflect further attempts to locate the sibling's father or notify him of the SCR report.

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

Action:
ACS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

PIP Requirement:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/06/2019	Other Child - Unrelated , Male, 3 Years	Other Adult - Unrelated , Female, 26 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Other Child - Unrelated , Male, 3 Years	Other Adult - Unrelated , Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unrelated , Male, 3 Years	Other Adult - Unrelated , Male, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Unrelated , Male, 3 Years	Other Adult - Unrelated , Male, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unrelated , Male, 3 Years	Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Unrelated , Male, 3 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unrelated , Male, 3 Years	Other Adult - Unrelated , Female, 26 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The Administration for Children's Services (ACS) received an SCR report that alleged the home the mother lived in with 2 unrelated adults and an unrelated 3-year-old child was deplorable. The home had dirty dishes, old food, garbage, dirty clothes, and other debris strewn throughout. The bathroom floors were saturated with water. The home was a health and safety concern. Additionally, the SCR report alleged one of the unrelated adults hit the child with a hanger using excessive force. As a result, the unrelated child sustained bruises. The other unrelated adult and the mother were aware and failed to intervene to protect the unrelated child.

Report Determination: Unfounded | **Date of Determination:** 07/07/2019

Basis for Determination:
ACS unfounded the SCR report against the mother and unrelated adults. It was determined the apartment in which the adults and unrelated child resided in was newly built and the child had adequate food and clothing. ACS assisted with obtaining beds for the residence. In addition, ACS found that the unrelated child did not have any marks or bruises.

OCFS Review Results:
ACS assessed the safety of the unrelated child throughout the investigation. The two unrelated adults and the mother were interviewed face-to-face. The home was not found to be in the condition as alleged in the SCR report. ACS provided beds for the home, completed a family team meeting, and addressed concerns as they were enumerated. ACS referred the unrelated female adult and unrelated child to preventive services. There were detailed supervisory consultations documented throughout the investigation. The determination was made in congruence with the evidence gathered. It was not documented that the biological father of the unrelated child was notified of the SCR report.

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

Issue:
Failure to provide notice of report

Summary:
The record did not reflect that ACS inquired about absent biological parents and that the unrelated child's biological father was notified of the SCR report.

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

Action:
ACS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

PIP Requirement:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/13/2018	Sibling, Male, 1 Years	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 1 Years	Other Adult - Unrelated , Female, 26 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The Administration for Children's Services (ACS) received an SCR report that the mother left the 4-year-old sibling in the aunt's care. The aunt was cognitively delayed and had mental health issues that prevented her from providing adequate care. The aunt had three children removed from her care in the past due to neglect. The mother knew this and left the sibling in the aunt's care despite being aware of this information.

Report Determination: Indicated | **Date of Determination:** 03/29/2019

Basis for Determination:
The allegation of Inadequate Guardianship against mother and unrelated adult was substantiated. ACS determined the mother left the sibling in the care of the unrelated adult, whom had mental health concerns and significant ACS history. The unrelated adult took the sibling with her to a medical appointment and was displaying erratic behaviors. The mother was called to retrieve the sibling, and it took her nine hours to do so. The mother did not make herself available during the investigation and there were ongoing concerns for the sibling’s safety.

OCFS Review Results:
ACS assessed the safety of the sibling within 24 hours of receipt of the SCR report. The mother and unrelated adult were interviewed, and the sibling was observed but not interviewed due to his age. ACS contacted several collateral sources throughout the investigation. Assessments were completed on time and with accurate information. The mother and sibling's whereabouts were unknown after ACS' initial contact with them. On 11/28/18, ACS filed a warrant to produce the sibling and on 11/29/18 the sibling was remanded and placed in relative foster care. The record did not reflect that the father of the sibling was notified of the SCR report.

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

Issue:
Failure to provide notice of report

Summary:
The record did not reflect that the father of the sibling was notified of the SCR report.

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

Action:

ACS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

PIP Requirement:

ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

In 2013, the mother had an indicated CPS investigation in NYC, in which her 1-month-old child died while in her care. It was determined the 1-month-old was sick, so the mother brought her to get medical care. The mother did not administer prescribed medication. The 1-month-old worsened and the mother did not seek further medical attention. According to the Medical Examiner, the 1-month-old died due to Bronchopneumonia with empyema complicating viral upper respiratory tract infection. The mother was indicated for LMC, IG and DOA/Fatality.

In 2015, the mother and 6-year-old sibling's father had an unfounded CPS investigation in NYC regarding the 6-year-old sibling. The report alleged concerns about the condition of the home and care of the sibling. Specifically, that the home had garbage, rats and roaches and the sibling had no food or diapers.

In 2016, the mother had an unfounded CPS investigation in Albany County regarding the 6-year-old and 5-year-old sibling. The report alleged concerns that the siblings were not regularly bathed or changed.

In 2018, the maternal grandmother had an indicated CPS investigation regarding the 6-year-old and 5-year-old sibling. ACDCYF determined the grandmother did not adequately supervise the siblings and on more than one occasion they were found outside of their residence alone. One of the instances was during the CPS investigation. ACDCYF filed a Neglect Petition and the siblings were placed in foster care.

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: 07/25/2018

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?	☐	☒	☐	☐

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? The FASP was due on 8/18/2021, submitted on 1/5/2022 and approved on 1/26/2022.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

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 maternal grandmother was provided services through community agencies.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☒Yes ☐No

Issue:	Timeliness of completion of FASP
Summary:	Two of the FASPS were completed more than five months after their due dates.
Legal Reference:	18 NYCRR428.3(f)

Action:	ACDCYF will complete, or see to the completion of FASPs by service providers when applicable, in a timely fashion when ACDCYF maintains a case management role.
Issue:	Adequacy of Preventive Services casework contacts
Summary:	There was no casework activity documented in the case record between 7/23/2021 and 12/16/2021.
Legal Reference:	18 NYCRR 423.4(c)(1)(ii)(d)
Action:	There must be at least 12 casework contacts with a child and/or family in receipt of preventive services within each six-month period of services. The first six-month time period commences at the case initiation date or at the initiation of preventative services; subsequent six-month periods will be calculated from the service plan due date.

Foster Care Placement History

In 2018, ACS determined the mother left the 4yo sibling in the care of a caretaker who had mental health concerns. The caretaker brought the sibling to a medical appointment with her and was observed acting erratically by medical personnel. ACS was notified and requested the mother retrieve the sibling from the hospital; however, she did not do so for nine hours. On 11/28/2018 ACS filed a Neglect Petition against the mother and on 11/29/2018, the sibling was placed in kinship foster care with an aunt. In 2020, the 1yo sibling was born and was admitted to the NICU with medical needs. The mother was not bonding with the sibling or responding to correspondence regarding a plan for the sibling. The aunt who had placement of the 4yo sibling was unable to care for the 1yo. On 5/20/2020, ACS filed a Neglect Petition against the mother and the sibling was remanded to foster care when discharged from the hospital. Since the siblings had been in foster care, the mother had not completed a mental health or substance misuse evaluation, completed a parenting class for children with special needs, obtained stable housing, visited with the children, or made a plan for their care. On 10/21/2021, the 1yo sibling's goal was changed from reunification with a parent to adoption via family court.

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:**
11/28/2018	There was not a fact finding	There was not a disposition
Respondent:	060354 Mother Female 26 Year(s)	
Comments:	On 11/28/2018, ACS filed a Neglect Petition against the mother regarding the 4-year-old sibling. The sibling was removed and placed in kinship foster care. The kinship foster parent was pursuing kinGap. Family court matters were ongoing.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/15/2020	There was not a fact finding	There was not a disposition

Respondent:	060354 Mother Female 26 Year(s)
Comments:	On 4/25/2020, the 1-year-old sibling was born and admitted to the NICU due to medical needs. The mother did not respond to correspondence regarding caring for the sibling. On 5/20/2020, ACS filed a Neglect Petition against the mother and the 1-year-old sibling was placed in foster care. On 10/21/2021, the sibling's goal was changed from reunification with a parent to adoption via family court. Family court matters were ongoing.

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