NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-076 **Prepared by: New York City Regional Office**

Issue Date: 2/10/2016

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
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		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 09/06/2015
Initial Date OCFS Notified: 09/15/2015

Presenting Information

According to the OCFS notification received from the preventive agency, New Alternatives for Children (NAC), on 9/8/15 the BM called the CP and reported that the two-year-old medically fragile child died on the morning of September 6, 2015. The BM reported she awakened around 4:30AM to provide the SC with his medications and fell back asleep. When she awakened at 7:30AM, she found the child dead. BM said she called 911 and when EMS arrived, they pronounced the SC dead.

Executive Summary

The two-year-old male child died in Bronx County on 9/6/15 at 9:13 AM, and was taken to a local hospital by EMS. According to the child's certificate of death, the hospital's doctor determined the child was 'Dead on Arrival' (DOA) and his death due to 'Natural Causes'. The SCR was not contacted. The family opted for no autopsy. According to the agency's notification to OCFS, the child was medically fragile and diagnosed with a chronic medical health condition. He was on multiple prescribed medications, 24-hour ventilation, and had 24-hour nursing care. The BM and SC resided with the MGM prior to his death.

SCR history noted that on 1/9/15, Emergency Medical Services (EMS) responded to a 911 call of a child in respiratory distress. EMS found the child unresponsive and in cardiac arrest, observed the home to be unsanitary, and the child to have a soiled diaper. EMS revived the child who was transported to a local hospital. An SCR report alleging IG and IFCS of the SC by the BM was registered on 1/9/15. ACS investigated the circumstances of the incident and unsubstantiated the allegations on 3/10/15; the report was UNF. CPS determined that the child was under the care of the nurse; the BM was not home. The nurse contacted the BM via phone at time of the incident, and the BM rushed back to the home following which 911 was called. The 'messiness' was due to the BM looking for medical equipment as the child was in respiratory distress. CPS found no credible evidence to support the allegations. The Shelter manager confirmed the family had moved in 2 days before the incident, and the nurse confirmed the home was usually appropriate. CPS did not record interviewing the licensed nurse caring for the medically fragile SC, regarding why his medical equipment was not readily available. The child was brain damaged as a result of the incident and remained hospitalized from January 2015 to August 2015.

The family was referred for preventive services with New Alternatives for Children (NAC), Medically Fragile program in May 2015. The NAC Registered Nurse (RN) and Case Planner (CP) conducted visits to the hospital and home to provide support and monitor services to the family. The BM relocated to the MGM's home from the shelter after the 1/9/15 incident and hospitalization of the SC. Progress notes were mostly contemporaneous and NAC met the statutory requirements for casework contacts. The last home visit (HV) before the child's death occurred on 8/19/15 by the CP and supervisor. The child was observed to be clean with no visible marks/bruises. The visiting nurses were in the home.

According to the record, on 9/6/15 at 4:00AM the BM gave the child his medication. When she woke at 7:50AM, she observed the nurse picking up the SC to change his diaper; the BM observed his tracheotomy was disconnected and the SC's color was "off". She ventilated the child with the Ambu bag (manual resuscitation bag) and the nurse called

Emergency Medical Services (EMS). Information regarding the services provided to the child by EMS was not documented by NAC.

Following the SCs death, two HVs were conducted to the case address by the NAC Social Worker/CP and Supervisor to offer support and obtain additional information about the SCs death; the BM gave an account of events surrounding the death. According to NAC, the BM provided three different accounts of events surrounding the child's death. On 9/23/15 OCFS requested NAC review the OCFS-7065 narratives and reassess whether NAC needed to utilize its role as mandated reporter based on the questionable circumstances around the SCs death. On 10/2/15 NAC responded, stating they did not believe the SCs death was due to any negligence on the part of the mother. On 9/29/15, the NAC CP and RN conducted a home visit and met with the BM and MGM during which the BM informed she was going to 'collect the child's ashes'. There was no funeral but a 'lighting ceremony' was planned to which the CP and RN were invited.

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?** No
  - **Safety assessment due at the time of determination?** N/A
- **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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:

Licensed nurses provided 24-hour care of the SC following his hospital discharge. At the 1/9/15 incident, the on-duty nurse was not questioned by ACS regarding why she was unable to properly suction the child's tracheotomy tube although she was allegedly trained in that skill. Nor was the nurse contacted by NAC to confirm the inconsistent information provided by the BM regarding the SCs death.

Was the decision to close the case appropriate?	Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:

ACS prepared and approved the Initial and Comprehensive FASPs. NAC provided services to the family for approximately 4 1/2 months during which support and services were provided/offered to the family. NAC appropriately closed the case as the circumstances no longer met the statutory eligibility criteria for preventive services; there were no surviving siblings in the home.

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: 09/06/2015 **Time of Death:** 09:13 AM

Time of fatal incident, if different than time of death: 07:30 AM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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? No
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	10 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	2 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	45 Year(s)
Deceased Child's Household	Mother	No Role	Female	21 Year(s)

LDSS Response

The mother contacted the preventive agency, NAC, on 9/8/15 to notify them of the child's death. She informed the Social

Worker/CP the child died on Sunday, 9/6/15.

On 9/9/15, the CP and NAC nurse conducted a HV with the BM to offer support as well as obtain additional information of the circumstances surrounding the child's death for which the BM provided details. BM also informed she had a lawyer and was planning legal action against the visiting nurse agency. NAC asked the BM if she needed bereavement or individual therapy. The BM declined, stating that the hospital social worker recommended a group that met 1X monthly for parents who lost their children. NAC staff informed BM information would be provided if she chose to go.

On 9/17/15 the NAC supervisor contacted the NYC Office of Medical Examiner inquiring if an autopsy was conducted on the SC. NAC was informed they would have to submit request in writing re same.

On 9/23/15 the NAC nurse contacted the visiting nurse agency and spoke with a supervisor. The supervisor confirmed that at time of the SC's death, two nurses were present for change of shift. The night nurse was an LPN, the day nurse was an RN; the supervisor did not provide further information.

On 9/23/15 the NAC nurse contacted the agency that provided respiratory equipment to the SC and left a message for the supervisor. There was no documented response from the agency.

On 9/29/15 the CP and supervisor conducted a HV with the BM. The BM was informed the PPRS case would be closed because there were no surviving siblings. The BM stated she was going to collect the SC's ashes on same date. The MGM was present and informed the family did not want an autopsy because the SC had gone through enough while he was alive; the family elected to have a 'Lighting Ceremony' to which the staff were invited. The BM disclosed feelings of anxiety around collecting the ashes as she already had the ashes of the SC's twin who had died at their birth. The BM shared that a close friend had recently passed and was somewhat comforted that the friend and SC's twin would be 'there with him'. The MGM disclosed she had a child who died at birth and had not fully recovered from that loss. The BM requested bereavement and individual therapy, and the CP then offered to "send information on groups and therapy options in her area". There was no documentation in the case record the CP provided the information to the BM.

9/30/15 progress note indicated the case would be closed as of 10/1/15. The services cases was finally closed in CONNECTIONS on 10/15/15.

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: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: N/A

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:

The SC's death was not reported to the SCR; no CPS investigation was conducted. The child died 9/6/15.

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?	☐	☐	☒	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: The surviving child in the household was the ten-year-old MA who was not assessed.				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☐	☒	☐	☐	☐
Economic support	☐	☐	☐	☒	☐	☐	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary:							

The agency documented home visits upon learning of the SC's death. However, there was no documented discussion with the BM around interment/funeral arrangements. And, following the BM requesting services and the MGM's disclosure of feelings associated with having a child death herself, there was no documentation the CP provided the referrals for the bereavement services as offered.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
The 10-year-old maternal aunt (MA) residing in the home was not engaged by the preventive agency during the services period; nor was she engaged regarding the fatality. The agency never documented efforts to communicate with and engage the MA.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Per documentation, the BM stated the hospital social worker suggested she participate in a group that met once a month for parents who lost their children; she was not ready to engage in bereavement services at that time. There was no record of NAC's attempts to locate, engage and/or contact the BF. On 9/29/15, the BM disclosed having some traumatic losses - deaths, and the MGM disclosed she had a child who also died at birth. The agency did not document offer/referral for supportive 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? 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? N/A
Was the child acutely ill during the two weeks before death? Yes

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)
01/09/2015	5142 - Deceased Child, Male, 2 Years	5141 - Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	5142 - Deceased Child, Male, 2 Years	5141 - Mother, Female, 21 Years	Inadequate Guardianship	Unfounded	
Report Summary:					

The report alleged BM was failing to provide adequate care for her 1-year-old child. The home was unsanitary, and the child was unkempt, unclean, and wore soiled diapers. The narrative stated that on 1/9/15, Emergency Medical Services (EMS) went to the home and found the child in cardiac arrest. The child was treated and transported to the hospital. The child had a visiting nurse.

Determination: Unfounded | **Date of Determination:** 03/10/2015

Basis for Determination:

CPS investigated and concluded the allegations were Unsub. The Inv. Conclusion was UNF - Case Open for services. Both the Shelter site manager and the Day-nurse confirmed to CPS the home was usually appropriate; the family had moved into the shelter two days prior to the incident. At time of the incident, the home was in disarray due to BM looking for the child's AMBU bag. The day-nurse denied the child was unkempt and stated the medically fragile child was always kept clean. The pediatrician reported the child was always clean when brought in for visits and the parents were very attentive to the child.

OCFS Review Results:

The allegations were investigated by CPS in that pertinent collaterals were contacted and interviewed. However, the circumstances surrounding the report were not thoroughly investigated. CPS recorded the SC went into cardiac arrest as a result of respiratory failure. EMS reported to CPS the SC was found unresponsive & was in cardiac arrest for about 10 minutes. The doctor stated the SC's heart stopped for 30 minutes. ACS failed to diligently interview the nurse regarding the circumstances surrounding the incident such as why the 'Ambu bag' was not accessible/working, why the SC's trachea was blocked with mucus; how often did he need suction, and what were the nurses' tasks.

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

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

ACS failed to adequately interview the nurse caring for the child at the time of the incident; particularly as the BM was not home at the time. There was no documentation of steps the nurse took when the child's vital signs began to drop nor the nurse's response regarding use of and accessibility to the medical equipment. The nurses' credentials and experience were not examined.

Legal Reference:

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:

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

Issue:

Timeliness of completion of FASP

Summary:

The Case Initiation date for this case was 3/24/15. The Initial FASP was launched and approved on 6/22/15. An initial FASP must be completed by the social services district, and must be approved by the case manager within 30 days from the case initiation date.

Legal Reference:

18 NYCRR 428.3(f)(5)

Action:

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

Issue:
Adequacy of case recording in FASP
Summary:
ACS prepared both FASPs for this case -- the Initial and Comprehensive-- and both FASPs were launched and approved on the same date, 6/22/15. ACS failed to have the family sign the FASP or document the family's involvement in the development of the service plan. There was no record the family received a copy of their service plan.
Legal Reference:
18 NYCRR 428.6(a)
Action:
ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issue.ACS must meet with staff involved and inform OCFS of the date of the meeting, who attended, and what was discussed.

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

Family does not have CPS history of more than three years.

Known CPS History Outside of NYS

Family did not have a 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: 03/24/2015

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

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:
24-hour Visiting Nurse services were provided for the medically fragile child. The Family Services Stage was opened 3/24/15 to provide case management services and monitor the child's special medical needs. In May 2015, the family was referred to, and began receiving preventive services with agency, New Alternatives for Children (NAC).

Required Action(s)

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

Issue:	Adequacy of case recording
Summary:	There was no collateral contacts with family members living in the home regarding the circumstances surrounding the child's death including the visiting nurse. It was unclear which family members were in the household at time of the SC's death.
Legal Reference:	18 NYCRR 428.5(c)
Action:	ACS must submit a corrective action plan (CAP) within 45 days that identifies what action it has taken or will take, to address the issue. The CAP must include the preventive agency's policies around collateral contacts and family engagement. The Preventive agency must meet with staff and inform OCFS of the date of the meeting, who attended, and what was discussed.

Preventive Services History

According to CONNECTIONS, on 5/21/15 the family began preventive services with New Alternatives for Children (NAC).
The BM was referred to NACs Special Medical program by CPS due to a 1/9/15 SCR report that alleged IG and IFCS of the SC by the BM. The SC was medically fragile and was diagnosed with a chronic medical health condition since birth. He was born premature at 25.9 weeks and was a twin; the male twin died a few hours post birth. On 1/9/15, EMS was called to the home and found the SC in cardiac arrest. EMS observed the home to be unsanitary and the SCs diaper was soiled. EMS transported the SC to a local hospital and he was admitted.

On 5/21/15, CPS and the NAC Case Planner (CP) conducted a joint home visit. The SC remained hospitalized. The initial plan included preparing the home for the SC's hospital discharge and case management services. The SC was discharged from hospital on 8/4/15 with 24-hour, 7-days a week visiting nursing care provided by Maxim Health Care Services; Prompt Care provided his medical equipment. The BM was trained by the hospital to care for the SC’s basic needs.

NAC's progress notes reflected casework activities that included visits to the hospital and home. Diligent efforts to locate and engage the BF who lived outside the home were not documented. The CPS case closing home visit was on 9/29/15.

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? There was no legal activity

Additional Local District Comments

N/A

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

Explain: The preventive agency, NAC, should make diligent efforts to clarify all discrepancies that occur when gathering information related to incidents/circumstances surrounding the death of a services-recipient child.

Given that NAC provides services to medically fragile children, the agency must make sure that social workers/case planners and other staff who are involved with a case family document casework activities conducted and/or make diligent efforts to locate and engage the BF's of services-recipient children; as well as assess whether to include the BF's, in their child's services plan. Also, family resources and supports (primarily maternal and paternal relatives), should be identified. The agency's attempts to engage and include them in the services plan; particularly if they resided in the same home, should be adequately documented.