Child Fatality Report

Report Identification Number: NY-17-034

Prepared by: New York City Regional Office

Issue Date: Sep 19, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 11 year(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 04/12/2017
Initial Date OCFS Notified: 04/13/2017

Presenting Information

The 4/13/17 SCR report alleged the 11-year-old SC was diagnosed with a medical illness and was prescribed medication. There was a history of the SM not ensuring that the SC took his medication which resulted in the SC having symptoms of illness and hospitalizations in the past. On 4/12/17, the SM placed the SC's medications into a bottle of water and left for work at 8:00 a.m. The SM did not make sure the SC took his medication before she left. At some point during the morning, the SC became ill. The SC was pronounced deceased on 4/12/17 at the Richmond University Hospital in Staten Island. The pre-existing medical condition was believed to be the cause of death. It was unknown, who or if anyone was in the home when the SC became ill, and it was unknown who called 911. The SF and SS had unknown roles. The SC had 79 days absent for the 2016-2017 school year and was failing as a result. The SM was aware of the SC's poor attendance and failed to ensure SC attended school regularly.

Executive Summary

The 11-year-old male child SC died on 4/12/17. As of 9/11/17, NYCRO had not yet received the autopsy report.

The allegations of the 4/13/17 report were DOA/Fatality, IG, EdN, LMC of the SC by the SM.

ACS convened an Initial Child Safety Conference on 4/24/17 and determined that the agency would request Court Ordered Supervision of the half-sibling through the Richmond County Family Court (RCFC), and offer the SM services. ACS was granted COS of the half-sibling on 4/27/17.

During the investigation ACS obtained information from the Investigative Consultant (IC), LE, half-sibling, SC’s school, and SC's physician. ACS also interviewed the SM and MGM.

During the interview of the SM it was reported that she woke up at 6:45 AM on 4/12/17 and observed the SC shaking vigorously. The SM said she observed the SC experiencing symptoms of illness and was responsive at the time he was shaking. The SM stated that she knocked on a neighbor’s door and requested that the neighbor contact 911. The SM said EMS did not arrive; therefore, she contacted a cab to transport the SC to the hospital. The SM reported that the SC was breathing while en route to the hospital. She transported the SC to Richmond University Medical Center (RUMC) and medical staff administered CPR on the SC; however, CPR resuscitation was unsuccessful and the SC died.

Subsequently, ACS learned that 911 was not called on 4/12/17; however, on 3/15/16, 3/9/16 and 5/17/16, EMS had responded to the case address for the SC. The SM reported that she administered SC’s medication and had done so by placing the SC’s medication in water. The SM said she did not recall notifying the Dr. that she placed the SC’s medication in water. The SM explained that she was informed by an ER nurse that it was okay to mix or crush the SC’s medication in his food. ACS observed the SC’s sippy cup to be a large water bottle with a safety lock. ACS staff also observed the SC’s medication stored in a bag that was placed high within the cabinet .

ACS staff contacted the SC’s Dr. ACS learned that the Dr. had not directed the SM to administer the SC’s medication by placing the SC’s medication in a sippy cup. The Dr. was unaware of the SM’s technique of administering the medication to the SC. The Dr. said the SC had been a patient at the clinic since 2013.

ACS contacted the SC's school and interviewed school staff who said the SM kept the SC home for days because of his illness. The staff had experienced difficulty contacting the SM and the MGM. The school staff said the SM was offered a nurse to accompany the SC to and from school daily and home schooling; however, SM denied the services. ACS learned that the SC was 2-3 years old cognitively and did not understand the significance of drinking all his water.

The ME reported that the SC was observed with minor abrasions in the healing state; consistent with the SC falling due to symptoms of the pre-existing medical condition. The ME said the SC was wearing a protective helmet to prevent injuries. The ME noted that there was no suspicion concerning abuse of the SC.

The half-sibling was interviewed and ACS learned that the half-sibling observed the SM giving the SC medications and had witnessed the SC spit out the medication after being administered by the SM. The SC's MGM was interviewed and ACS learned that the MGM had no concerns regarding the care of the SC. The MGM said that the SM attended Dr.'s appointments and took the SC to the Dr. as needed.

ACS sought COS and was granted supervision of the family through the RCFC. The family received preventive services at Seamen's Society General Preventive program.

As of 9/11/17, the case remained open in the investigation and Family Services stages.

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?** 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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
As of 8/15/17, ACS had not yet completed 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:
As of 9/11/17, ACS had not yet completed the investigation that began on 4/13/17.

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: 04/12/2017 **Time of Death:** 09:30 AM

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

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	11 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Other Child - Half Sibling	Alleged Victim	Female	9 Year(s)

LDSS Response

On 4/13/17, the ACS Instant Response Team (IRT) learned that the SC's body was at the ME's office. ACS was notified that the SM brought the SC to the hospital and NYPD was contacted. ACS learned that the SC had a 9-year-old half-sibling, who lived in the home.

On 4/13/17, ACS conducted school clearances of the SC and the half-sibling. ACS documented that the SC was present a total of 53 days and absent 76 days for the 2016-2017 school year. The half-sibling had a total of 24 days absent for the 2016-2017 school year.

ACS attempted 24-hour contact with the SM and half-sibling; however, the attempt was unsuccessful. ACS contacted the SM by phone and learned she was staying with the MGM. ACS visited the MGM's home and obtained the SM's account of the incident. The SC's MGM was interviewed and she reported there were no concerns regarding the SM's care for the SC and half-sibling.

On 4/14/17, ACS contacted the EMS liaison and was notified that there was no 911 call on 4/12/17; however, there were calls on 3/15/17, 3/9/17 and 5/17/17. ACS visited the Richmond University Medical Hospital on 4/14/17 and reviewed the attending physician's notes from the ER.

ACS staff verified that the information regarding SC's death was obtained from the ME's office. ACS staff learned that the SM struggled to ensure that the SC took his medication.

On 4/14/17, ACS consulted with the Investigative Consultants and obtained criminal background and domestic incident history regarding the SM. ACS learned that the SM had no criminal history or current OP. The SM had incidents of domestic violence, involving the half-sibling's BF.

ACS staff received a call from the ME who reported that the SC's test was pending. The ME also notified ACS that the SC was wearing a protective helmet and there was no suspicion concerning abuse of the SC. ACS offered the SM burial assistance.

On 4/17/17, ACS obtained a medical consult. The consultant stated that the SC's, "illness was terminal." ACS staff also learned that the SC's medical condition could have contributed to his absences from school. ACS staff contacted the SC's medical specialist who said there were no concerns regarding the SM's ability to follow through with SC's medical needs.

ACS conducted a home visit to verify the method in which the SM administered the SC's medication. ACS observed a large water bottle with a safety lock and the SC's medications, and reviewed the labels.

ACS staff held an Initial Child Safety Conference on 4/24/17, to address allegations of LMC. ACS staff sought a legal consultation. On 4/24/17, ACS filed an Article Ten Neglect petition in the RCFC as a result of the current fatality and on behalf of the half-sibling. The judge released the half-sibling to the SM, with COS on 4/27/17.

On 6/1/17 and 6/9/17, ACS visited the home to assess the half-sibling. The SM stated that she was overwhelmed. ACS staff discussed the benefits of preventive services with the SM. The SM informed ACS that she needed assistance with food. ACS staff returned to the case address on 6/9/17 and provided emergency food for the family. The ACS staff followed up with the SM and her counseling referrals. ACS notified the SM that a preventive services agency was assigned to the family.

On 8/3/17, ACS conducted a joint home visit with the Seamen's Society for Children and Families agency. This agency agreed to assist the SM with housing and public assistance.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
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
040161 - Deceased Child, Male, 11 Yrs	040181 - Mother, Female, 30 Year(s)	DOA / Fatality	Pending
040161 - Deceased Child, Male, 11 Yrs	040181 - Mother, Female, 30 Year(s)	Educational Neglect	Pending
040161 - Deceased Child, Male, 11 Yrs	040181 - Mother, Female, 30 Year(s)	Lack of Medical Care	Pending
040161 - Deceased Child, Male, 11 Yrs	040181 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Pending

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?	☐	☒	☐	☐
Caretakers / Babysitters	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The investigation progress notes were entered within 30 days of the event.

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?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine

Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving 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 regarding 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:**
04/24/2017	There was not a fact finding	Order of Supervision
Respondent:	040161 Deceased Child Male 11 Yrs	
Comments:	On 4/24/17, ACS filed an Article Ten Neglect petition in the RCFC as a result of the fatality and on behalf of the half-sibling. The judge released the half-sibling to the SM, with COS.	

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:
ACS referred the family for PPRS.

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 half-sibling was engaged in tutoring and counseling. ACS also contacted the half-sibling's school and spoke with the school social worker regarding the incident.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS referred the SM to bereavement counseling and PPRS. ACS requested COS for case management of the family.

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? No
Was the child acutely ill during the two weeks before death? No

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)
12/13/2016	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unfounded	Yes
	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Lack of Medical Care	Unfounded	

Report Summary:
The 12/13/16 SCR report alleged that the SC had a pre-existing medical condition and was prescribed medications to be taken twice daily. The report also alleged the SM did not administer the SC's medication at home in the mornings and had not provided the school with a letter from the physician allowing the medication to be administered to SC while he was at school. As a result on 12/13/16, the SC did not take his morning medications and SC became ill; which, resulted in

his hospitalization. The SM was contacted and did not answer the phone or show up to the hospital. The BF had an unknown role.

Determination: Unfounded | **Date of Determination:** 02/15/2017

Basis for Determination:
The allegation of IG and LMC of the SC by the SM were unsubstantiated. ACS documented that the SM was a working single parent who had a child who had an illness. ACS added that the SM knew the only way the child would take his medication was in a water bottle. The SC's school was knowledgeable about what to do in case the SC had a seizure. The SM had a new job and had to take public transportation everywhere. The SM had to get permission to leave work and then took the bus to the hospital. The SM had always been cooperative and was able to take the SC for preventive medical care. The SM had been resourceful and caring. The home was appropriate and there were no concerns noted.

OCFS Review Results:
The results of the review showed ACS entered timely progress notes. ACS did not make thorough assessments regarding the family's needs or relevant collateral contact with the ACS medical consultant. ACS did not address the specific concerns regarding the SM's method of administering the SC's medication. ACS did not conduct relevant clearances on the SM's neighbor who was babysitting the CHN. The family was not receiving services at home. The SM notified ACS that she was interested in a variety of services; however, ACS did not follow-up with the SM regarding the services she was interested in. ACS did not contact the fathers of the SC and half-sibling.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS did not make collateral contact with the medical consultant although the SC was medically fragile.
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 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 Medical care of child
Summary:
ACS did not address the concerns of the 12/13/16 report that included the SM administering the SC's medication in a water bottle. ACS did not make a thorough assessment to inquire whether the SM needed assistance in administering the SC's medication or education around SC's illness and medication management. ACS did not request a school or family meeting to address the medical concerns.
Legal Reference:
18 NYCRR 441.22
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.

Issue:
Failure to Offer Services
Summary:
There was no documentation indicating that the ACS staff offered the SM services; although, the SM requested assistance with possible nursing, and Medicaid coordination. In the 1/25/17 progress note, the SM reported needing assistance and appeared overwhelmed; however, ACS did not offer a referral for services or assistance in locating

services that could help the SM and CHN.

Legal Reference:

SSL 424(10); NYCRR 428.6

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.

Issue:

Pre-Determination/Supervisor Review

Summary:

The decisions made pertaining to all the allegations or concerns were not clearly stated in the supervisor review. The 12/13/16 report was approved unfounded by the supervisor although the manager and supervisor directives/questions were not answered.

Legal Reference:

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

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.

Issue:

Appropriateness of allegation determination

Summary:

ACS did not thoroughly address the allegation of IG and LMC in the CPS Investigation Summary. ACS unsubstantiated these allegations, but did not document throughout the investigation the SM's rationale for placing the SC's medication in the water bottle. ACS did not document whether the SC's Dr. approved of the manner the SM administered the medication and if it was recommended.

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(c)

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 known to the SCR and ACS in a report dated 2/7/07. The allegation of the report was IG of the SC and other children who resided in the home by the SM and the children's other caretaker. On 4/3/07, ACS unsubstantiated the allegation of the report. The report was unfounded.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Required Action(s)

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

☒ Yes ☐ No

Issue:	Adequacy of Progress Notes
Summary:	The Family Services Progress Notes were not entered contemporaneously or within the required 30-day timeframe. There were progress notes of event that occurred in April and May 2017 that were not entered until 7/10/17.
Legal Reference:	18 NYCRR 428.5
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.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP within the FASP did not reflect that the SM was a victim of abusive or threatening incidents with partners or adults, and one or more basic family needs were intermittently or chronically unmet
Legal Reference:	18 NYCRR 432.2(d)
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.

Preventive Services History

There is no record of Preventive Services 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

There are no additional LDSS 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