Child Fatality Report

Report Identification Number: NY-17-144

Prepared by: New York City Regional Office

Issue Date: Jun 18, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 5 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 12/25/2017
Initial Date OCFS Notified: 12/25/2017

Presenting Information

On 12/25/17, the SCR registered a subsequent report alleging DOA/Fatality, and Inadequate Guardianship of the five-year-old male subject child (SC). The SC's biological parents were the subjects of the report.

The narrative of the report alleged at approximately 7:03 A.M. on 12/25/17, the BM had the SC on the couch because he was not breathing and the BF called 911. Sometime during the night, the BF heard the SC snoring so he turned on a humidifier and applied some vapor rub on the SC. At some unknown time, the BF noticed that the SC stopped snoring. It was unknown how long the SC had stopped breathing before the parents noticed or called 911. The SC's jaw was stiff when Emergency Medical Services arrived at the home. The SC was transported to the hospital where he was pronounced dead. The SC was reported to have a pre-existing medical condition.

Executive Summary

The 5-year-old male SC died on 12/25/17 while in the care of his biological parents (BPs). The ME's report had not been finalized. ACS' documentation revealed that on 12/24/17, the SC suffered from a cough and chest pain and the BM gave the SC over the counter medication and he appeared normal. At approximately 1:00 AM on 12/25/17, the SC fell asleep on the couch. At 6:00 AM, the BF noticed the SC was not breathing. The BF called 911 while the BM gave the SC CPR until EMS arrived. EMS arrived at the home within moments and took over the resuscitation efforts then transported the SC to the hospital where medical staff pronounced him dead. The SC had a pre-existing medical condition. The entire family had the same diagnosis as the SC. The SC had a 7-month-old surviving sibling (SS).

Following the fatality, the BPs arranged for the maternal great aunt (MGA) who resided out of state, to temporarily care for the SS. LE from the state the MGA resided in conducted a courtesy home visit and assessed the SS to be "safe and sound" with the MGA.

ACS initiated the CPS investigation in a timely manner. ACS conducted home visits and contacted relevant collaterals during the investigation. The information received from the collaterals did not reveal the SC was abused or neglected. LE did not find any criminality and no arrests were made.

On 4/4/18, the SCR registered a subsequent report that alleged on 12/25/17, the BPs gave the SC three pills of Oxycodone. As a result, the SC died.

On 4/5/18, the ME reported that toxicology findings revealed a lethal dosage of Oxycodone in the SC's body. The BPs denied knowledge of how the SC ingested Oxycodone. ACS conducted an emergency removal of the SS from the BPs' care.

On 4/6/18, ACS filed an Article 10 Neglect petition in Manhattan Family Court (MFC) against the BPs for the SS. Family Court granted a remand of the SS and he was placed with the New Alternative for Children agency. The BPs were granted visitation with the SS.

At the time of writing this report ACS had not yet determined the CPS investigation and the SS remained in foster care. The BPs continued their visits with the SS but declined ACS' offer of services. The BP's stated they had secured their own bereavement counseling services. The LE investigation remained active.

PIP Requirement
A PIP is required for this fatality report.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** 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

Was the decision to close the case appropriate? N/A
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:
The case is opened for services.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30 Day Safety Assessment was completed on 1/30/18; which was five days past the due date.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or has taken to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/25/2017 **Time of Death:** 07:40 AM

County where fatality incident occurred:	New York
Was 911 or local emergency number called?	Yes
Time of Call:	Unknown
Did EMS respond to the scene?	Yes
At time of incident leading to death, had child used alcohol or drugs?	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: Not impaired.

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	5 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Month(s)

LDSS Response

On 12/25/17, ACS contacted the ER Dr., LE, and EMS personnel and they did not report any indication of neglect or abuse to the SC. The LE staff informed ACS no arrests were made pending further investigation.

ACS visited the family at the case address. ACS assessed the home and deemed it safe at the time of the visit. The SS was not present at the time of the visit. He was with the MGA who resided out of state.

On 12/26/17, LE from the state the MGA resided in conducted a courtesy home visit and assessed the SS to be “safe and sound” with the MGA.

On 12/28/17, ACS visited the family. The BPs declined an interview with ACS. They stated they needed more time to mourn their loss. They reported the SS was still with the MGA. ACS assessed the home with no concerns.

On 1/11/18 and 1/17/18, the children's medical providers reported that the BPs utilized ER services for their children's medical needs and often missed the children's medical appointments. The SS' medical condition was complicated but he did not require home health aide services. Also, the BPs did not require any specialized training to care for the SS.

On 1/18/17, ACS held a child safety conference (CSC) for the family. The CSC recommended PPRS services for the family. The BPs stated they were not ready for services.

On 2/2/18, the ME reported the final autopsy was pending additional tests.

On 2/9/18, the SC's school staff did not report any concerns for the SC or the BPs.

On 2/2/18, 2/13/18, and 2/28/18, ACS visited the family and assessed the SS to be safe during the visits. The BPs reported they had kept all the SS' medical appointments and would continue to do so. They declined ACS' offer of services.

On 2/28/18, ACS held a follow up CSC and recommended that the BPs submit to a random drug tests. The BPs refused to take a drug test.

On 4/4/18, the SCR registered a subsequent report that alleged on 12/25/17, the BPs gave the SC three pills of Oxycodone. As a result, the SC died. The SS had an unknown role.

Following the receipt of the report, ACS conducted a home visit and observed the SS sleeping in a Pack and Play. There were no concerns for the SS. ACS attempted to discuss safe sleep with the family but the BPs refused to speak with ACS. They stated ACS was re-traumatizing the family.

On 4/5/18, the ME reported that toxicology findings revealed a lethal dosage of Oxycodone in the SC's system. The ME stated the prescribing Dr. confirmed that on 9/8/17, a prescription was filled by the BPs for 10 milliliters of liquid Oxycodone for the SC. The dosage was 1.5 milligrams every 4 hours as needed. Per the Dr., Oxycodone did not have an appealing taste for a 5-year-old child and the bottle was child-proof. The ME stated the BM did not disclose the SC was prescribed Oxycodone in any of her conversations with the ME and LE.

Later that same day, ACS conducted an emergency removal of the SS from the BPs' care. The BPs denied knowledge of how the SC ingested Oxycodone.

On 4/6/18, ACS filed an Article 10 petition in MFC against the BPs for the SS. The MFC granted a remand for the SS and visitation of the SS for the BPs. ACS explored kinship resources for the SS but the resources provided by family were found to be unsuitable.

On 4/26/18, the BPs' Article 10 petition was heard in MFC. ACS reported that the BPs were visiting the SS weekly. The BM asked that the MGA be explored as a resource for the SS. The MFC requested ACS to commence an Interstate Compact on the Placement of Children for the SS. The MFC asked the BPs to submit to a random drug test but they refused based on their attorney's advice.

Between 5/3/18 and 5/31/18, ACS made several casework contacts with collaterals and the family. There was no new information regarding the fatality. The ME's report had not been finalized.

At the time of writing this report, ACS had not yet determined the investigation. The SS remained in foster care and the LE investigation was ongoing.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: New York City does not have an 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
043281 - Deceased Child, Male, 5 Yrs	043283 - Father, Male, 32 Year(s)	DOA / Fatality	Pending
043281 - Deceased Child, Male, 5 Yrs	043282 - Mother, Female, 27 Year(s)	Poisoning / Noxious Substances	Pending
043281 - Deceased Child, Male, 5 Yrs	043283 - Father, Male, 32 Year(s)	Poisoning / Noxious Substances	Pending
043281 - Deceased Child, Male, 5 Yrs	043282 - Mother, Female, 27 Year(s)	DOA / Fatality	Pending
043281 - Deceased Child, Male, 5 Yrs	043283 - Father, Male, 32 Year(s)	Inadequate Guardianship	Pending
043281 - Deceased Child, Male, 5 Yrs	043282 - Mother, Female, 27 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?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐

Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

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

Explain:
The 30 Day Safety Assessment was completed on 1/30/18; which was five days past the due date.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
On 4/5/18, the ME reported that toxicology findings revealed a lethal dosage of Oxycodone in the SC's system based. The BPs denied knowledge of how the SC ingested Oxycodone. Consequently, ACS conducted an emergency removal of the SS from the BPs' care. On 4/6/18, ACS filed an Article 10 Neglect petition in Manhattan Family Court against the BPs for the SS. The MFC granted a remand for the SS and he was placed with New Alternative Children.

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	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	☐	☐	☐	☐	☐	☒	☐

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? Yes
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? 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)
05/23/2015	Deceased Child, Male, 2 Years	Father, Male, 29 Years	Inadequate Guardianship	Unfounded	No
	Deceased Child, Male, 2 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The then 2-year-old SC lived with his MA (name unknown) but visited his parents' home on weekends. There were concerns that the BF physically assaulted the BM while the SC was present in the home. The SC had been knocked down by the parents during past altercations. Additionally, there was a concern that both parents sold drugs out of the home.

Determination: Unfounded **Date of Determination:** 07/21/2015

Basis for Determination:
There was no credible evidence found to suggest that the alleged event that prompted the investigation occurred. The parents only had community visits on Sundays in the neighborhood. The visits did not occur in the parents' home. Neither the FM nor the CP had any concerns with the SC upon returning from visits with the parents. The parents were actively engaged in court mandated services at the time. Also, the parents were testing negative for all substances. They denied any current DV and there were no current DIRs on file for DV between the parents at time of investigation.

OCFS Review Results:
The level of casework activity for this investigation was sufficient as ACS made contacts with relevant collaterals during the investigation. The FM and the CP did not have any concerns for the SC when he returned from visits. The only collateral contact that suggested the incident occurred had a history of altercations with the BM. Prior to the investigation, the BM and the collateral were involved in two altercations with one another which led to their arrests. ACS' decision to unsubstantiate the allegation IG of the SC by the parents was appropriate.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/22/2014	Deceased Child, Male, 2 Years	Father, Male, 28 Years	Inadequate Guardianship	Indicated	No
	Deceased Child, Male, 2 Years	Father, Male, 28 Years	Parents Drug / Alcohol Misuse	Indicated	
	Deceased Child, Male, 2 Years	Mother, Female, 23 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 2 Years	Mother, Female, 23 Years	Lack of Supervision	Indicated	
	Deceased Child, Male, 2 Years	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Indicated	
	Deceased Child, Male, 2 Years	Father, Male, 28 Years	Lack of Supervision	Indicated	
	Deceased Child, Male, 2 Years	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Deceased Child, Male, 2 Years	Father, Male, 28 Years	Inadequate Food / Clothing / Shelter	Indicated	

Report Summary:
The bio-parents (BPs) engaged in domestic altercations on an ongoing basis in the presence of their medically fragile 2year-old child. On 8/21/14, the BF physically assaulted the BM while she was holding the child in her arms. The child was not physically harmed.

On 8/31/14 and 9/2/14, the SCR registered subsequent reports alleging drug use by the BPs. On 9/4/14, ACS closed the two reports as duplicates and investigated the 8/22/14 report.

Determination: Indicated | **Date of Determination:** 09/19/2014

Basis for Determination:
ACS found credible evidence to support the allegations of IG, I/F/C/S, PD/AM, and LS against the BPs. The BPs engaged in regular physical altercations in the presence of their son. Additionally, the BPs used marijuana and resided in a home that did not have gas or running hot water. The home was inappropriate for the child who had a medical condition.

Although the family had an active service case and had completed DV services, they continued to engage in DV in the presence of their son. On 9/3/14, ACS filed an Article 10 Neglect Petition in Queens Family Court against the BPs. The SC was remanded and placed with New Alternatives Foster Care Services.

OCFS Review Results:
ACS initiated the investigation in a timely manner. ACS conducted home visits and contacted relevant collaterals during the investigation. On 9/3/14, ACS held a child safety conference (CSC). The participants at the CSC agreed to Family Court involvement to protect the 2-year-old SC. Consequently, ACS filed an Article 10 Neglect Petition in Queens Family Court against the BPs. The SC was remanded and placed in a medically fragile foster home under the auspices of New Alternatives for Children Foster Care Services due to his medical condition. The BPs were mandated to complete drug treatment, mental health services, parenting skills and batterer's services.

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

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

The parents were both known to the SCR and to ACS from numerous indicated reports when they were children.

The first report as parents was from an indicated report dated 10/4/13. According to the case records, there was a limited OOP against the BF, but he and the BM continued to engage in verbal disputes in the presence of the SC which often led to the BM calling LE and the BF getting arrested.

On 11/20/13, ACS substantiated the allegation IG against the BPs. ACS referred the BPs to counseling. The BM was also referred for anger management and was advised to enter a DV shelter. The family would continue to receive PPRS services from Community Mediation Services, Inc. The BM was also provided with information for the Queens Family Justice Center for additional assistance.

Known CPS History Outside of NYS

The family did not have any known CPS history outside of New York State.

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: 05/31/2013

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: On 5/31/13, an FSS Stage was opened for the family to receive PPRS services with Community Mediation Mental Services agency due to the parents' domestic violence history.				

Preventive Services History

Between 7/23/13 and 9/15/14, the family received PPRS services with Community Mediation Mental Services due to the BPs' ongoing DV in the presence of their son, and their misuse of marijuana. The services the family received included clinical services, parenting skills, DV, early intervention, family support/healthy marriage education and batterer's services. On 9/15/14, the family began services with New Alternatives For Children where they completed parenting, clinical health, and drug treatment services. The BF completed batterer's accountability services and the BM received DV services. Both BPs reported the services were helpful to them. The service provider described the BPs as very engaged in their counseling.

Foster Care Placement History

On 9/03/14, ACS filed an Article 10 Neglect Petition in Queens Family Court against the birth parents due to ongoing physical and verbal violence in the presence of the SC and ongoing abuse of marijuana. The SC was remanded and placed with New Alternatives Foster Care Services. The parents were mandated to complete drug treatment, mental health services, parenting skills and batterer's intervention services. On 7/28/16, the SC was trial discharged to his parents, and was final discharged on 9/22/17. The next court date was scheduled for 1/9/18 for permanency hearing.

The last documented home visit with the family occurred on 9/11/17 at the case address and there were no safety concerns noted. The SC and his four-month-old brother were present and appeared healthy and well cared for.

The last documented face to face contact with the family was on 9/22/17 at the agency where they participated in the final discharge conference.

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:**
09/04/2014	Adjudicated Neglected	Return to Parent
Respondent:	043282 Mother Female 27 Year(s)	
Comments:	On 9/4/14, ACS filed an Article 10 Neglect Petition in Queens Family Court against the birth parents due to ongoing physical and verbal violence in the presence of the SC and ongoing abuse of marijuana. The SC was remanded and placed with New Alternatives Foster Care Services due to his medical condition.	

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