Child Fatality Report

Report Identification Number: NY-18-059

Prepared by: New York City Regional Office

Issue Date: Dec 04, 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: 15 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 06/03/2018
Initial Date OCFS Notified: 06/04/2018

Presenting Information

The 6/4/18 SCR report alleged the SC suffered from pre-existing medical conditions. The SC struggled with illness for two years; resulting from the SM not seeking adequate medical attention in the past. On the evening of 6/2/18, the SC complained of illness. The SM administered an aspirin to the SC and put her to bed. The SM woke the SC up at 4:00 AM on 6/3/18 to check on her. The SC appeared fine. The SM and MA observed the SC awake at 9:30 AM before the MA left for work. The SC's condition was unspecified. The SM and SC returned to sleep. The SM woke up at 1:00 PM and went to check the SC and she was not breathing. The SM called 911 and the authorities responded to the home. The report alleged the SC died due to the SM failing to seek medical treatment for the SC. The roles of MA, 12, 10, and eight-year-old SS were unknown.

Executive Summary

This 15-year-old female SC died on 6/3/18. According to the ME, the manner and cause of the SC's death was pending further studies. NYCRO had not yet received the ME's autopsy report at the time of issuance of this fatality report.

At the time of the fatality, the family had an open preventive services case as they were being supervised by ACS and received PPRS.

The 6/4/18 SCR report included the allegations of DOA/Fatality, LMC and IG of the SC by the SM.

ACS interviewed the SM regarding the circumstance surrounding the death of the SC. ACS learned that on 6/2/18, at approximately 1:00 PM, the SC returned home from school with complaints of illness. The SM gave the SC one over-the-counter pain pill. The SM monitored the SC throughout the night. On 6/3/18 at around 3:00 AM, the SC awoke and then returned to sleep at around 5:30 AM. At approximately 8:00 AM, the MA prepared to leave for work; the SC was in the bed and appeared well at that time. At about 1:00 PM, the SM went to the bedroom to wake the SC; however, the SC was unresponsive. The SM observed the SC was not breathing. The SC was cold and stiff when the SM touched her. The SM called 911 and followed the operator's CPR instructions. The three SS witnessed the SM perform chest compressions. The SM performed CPR for approximately 15 minutes with no change in the SC's condition. The SM discontinued CPR efforts before the EMS arrived. ACS noted inconsistencies in statements regarding the SM performing CPR and the SC's medical appointments.

ACS was unable to conduct an interview or complete an adequate 24-hour safety assessment of all the SS due to the SM and their father's refusal and to provide ACS the whereabouts the SS. ACS conducted scheduled and unscheduled visits to various relative's homes. The family was elusive and difficult to engage. ACS staff located the SS; however, the parents did not allow ACS to enter the home. ACS staff performed visual assessments of the SS and the parents did not allow interviews of the SS. The SS appeared safe and were observed to be free of marks and bruises. ACS did not observe behavior, nor were statements made by the SM to suggest there were DV, substance abuse or MH issues in the home.

A Child Safety Conference (CSC) was held; ACS offered services and necessary referrals were made. ACS made several attempts; however, the SM refused further face-to-face and telephone communication with ACS. Through a family arrangement, the father relocated the SS to Broome County. ACS collaborated with Broome County Department of Social Services (BCDSS) to assess the SS. The service case progress notes showed BCDSS continued to monitor and support appropriate service delivery to the family under the court order of supervision. On 10/26/18, BCDSS assessed the SS for

safety. The SS appeared healthy and safe; no concerns were noted.

ACS had not made a determination of the report at the time of issuance of this fatality report.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Explain:
ACS had not made a determination of the report at the time this fatality report was completed.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ACS had not yet completed the investigation at the time this fatality report was completed.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The SCR report was dated 6/4/18. The 24-Hour Fatality Report document was approved on 6/8/18, not within the required time.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this

	fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The SCR report was dated 6/4/18. The 24-Hour Safety Assessment document was approved on 6/8/18; not within the required time.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30-Day Safety Assessment was not completed or submitted for approval.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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: 06/03/2018 **Time of Death:** 01:13 PM

Date of fatal incident, if different than date of death: 06/04/2018
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 01:07 PM
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
How long before incident was the child last seen by caretaker? 3 Hours
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	Aunt/Uncle	No Role	Female	32 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	15 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)

LDSS Response

On 6/4/18, ACS assessed the SS and the living environment. The SM did not allow ACS to enter the home or interview the SS. ACS observed the 11-year-old SS appeared well-groomed and free of suspicious marks or bruises. The whereabouts of the two remaining SS were unknown.

On 6/6/18, the school staff had no concerns regarding the SS's. The staff said the SM attended the SS's conferences. The school staff planned to offer bereavement counseling to the three SS's upon their return to school.

On 6/6/18, the ME said further test results were pending.

According to the CP, the family began services six months prior to the fatality for concerns of medical neglect. The CP last assessed the SC and SS on 5/22/18; there were no safety concerns regarding the SC and SS in the home. The CP stated the SM followed-up with the SC’s medical appointments and the SC received medication as prescribed. The CP stated the SM was compliant with PPRS. The family was wait-listed for multiple special medical service programs.

On 6/6/18, EMS stated the 911 call was received on 6/3/18 at 1:07 PM. Upon EMS arrival, the SC was in full cardiac arrest. The SM was performing CPR and the SC showed obvious signs of death.

On 6/6/18, LE stated the SC appeared to have died of natural causes. LE remained at the scene until the ME responded to the home. LE found no criminality and no arrest was made.

On 6/6/18, the father of the three SS stated he did not reside with the family. He spoke with the children daily. According to his account, the SC was administered her medication as prescribed. The SC brought her medication and took it daily when she and the SS visited his home. The father did not have concerns regarding the care the SM provided to the children. He had a discussion with the SM for the SS to relocate to reside with him out of ACS jurisdiction.

On 6/6/18, the godparent (GP) stated since the SC death, the two younger SS stayed with her and the eldest SS remained with the SM. The GP said the SS visited regularly and occasionally spent the night. The GP had no concerns about the SM’s care of the SS.

ACS assessed the two youngest SS at the GP's home. The SS appeared well groomed and free of visible marks or bruises. The SS were aware the SC had health issues; however, neither had knowledge of the cause of the SC's death.

On 6/8/18, the SM, MA and CP attended the CSC at the LDSS office. The family's strengths and challenges were discussed. ACS recommended continued COS and PPRS. ACS offered services and the SM accepted funeral/burial assistance.

According to the MA, she spent the night at the family's home. On 6/3/18 at approximately 8:00 AM, the MA saw the SC and she appeared healthy.

On 7/20/18, the children's physician said there were no concerns about the family. The children had up to date immunizations and the SC was compliant with her medications. The SC's medical specialist had concerns regarding the SM's non-compliance with the SC's attendance to monthly appointments. The SM and SC were trained to monitor the SC's medical condition and administer the SC's medication.

On 7/23/18, ACS requested BCDSS to complete a courtesy home visit to the father's home. On 7/24/18, BCDSS informed ACS that the SS resided with their father in a shelter since 7/11/18. BCDSS continued ongoing monitoring and assessments of the family as the SS resided out of ACS jurisdiction.

On 8/17/18, BCDSS staff assessed the 2-bedroom home was hazard free. The SS appeared to be safe and were free of visible marks and bruises. BCDSS verified the SS had medical insurance and were enrolled in school.

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)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046551 - Deceased Child, Female, 15 Yrs	046552 - Mother, Female, 35 Year(s)	DOA / Fatality	Pending
046551 - Deceased Child, Female, 15 Yrs	046552 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Pending
046551 - Deceased Child, Female, 15 Yrs	046552 - Mother, Female, 35 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐

Additional information:
The SM did not allow ACS to interview the SS regarding the circumstances surrounding the SC's death.

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:
ACS was unable to conduct an interview or an adequate 24-hour safety assessment of all the SS due to the SM's refusal and to provide ACS the whereabouts of the SS. ACS assessed the SS on 7/9/18.

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

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	☐	☐	☐	☐	☐	☒	☐

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 SM did not allow ACS to interview the SS regarding the circumstances surrounding the SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The SM was elusive and difficult to engage.

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? Yes
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)	Allegation Outcome	Compliance Issue(s)
01/10/2018	Sibling, Male, 11 Years	Mother, Female, 35 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Male, 7 Years	Mother, Female, 35 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 9 Years	Mother, Female, 35 Years	Educational Neglect	Unsubstantiated	

Report Summary:
The 1/10/18 SCR report alleged the three SS had excessive school absences during the school year. The last day the SS attended school was on 12/22/17 and they had not returned. The SS were not receiving home schooling or tutoring services. They were falling behind academically as a result of their absenteeism. The SM was aware of the situation, but there was no improvement.

Report Determination: Unfounded | **Date of Determination:** 03/09/2018

Basis for Determination:
On 3/14/18, ACS unsubstantiated the allegation of EdN of the three SS by the SM on the basis that the SS were not failing academically despite having missed two weeks of school.

OCFS Review Results:
ACS made face-to-face contact with the subject, SS and SC in home. ACS made collateral contacts with the PPRS CP, the SS's school pertaining to the allegations, and the SC's medial providers. ACS provided the SM a notification.

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

Issue:
Failure to provide notice of report

Summary:
ACS did not provide the father of the SS a NOE.

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

Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
ACS did not follow up with the SC's school staff regarding her attendance and adherence to the medication treatment plan.

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

Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/29/2017	Deceased Child, Female, 14 Years	Mother, Female, 34 Years	Inadequate Guardianship	Substantiated	Yes

Deceased Child, Female, 14 Years	Mother, Female, 34 Years	Lack of Medical Care	Substantiated
Sibling, Male, 7 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 7 Years	Mother, Female, 34 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
The 9/29/17 SCR report alleged the 14-year-old SC was diagnosed with a pre-existing medical condition eight months prior to the 9/29/17 report. Since that time the SC received treatment in the hospital. The SC was required to have tests four times daily, at which times, she was to have medication administered. The SM failed to regularly test the SC and administer the medication. The SM failed to to take the SC to follow-up appointments with the medical specialist.

A 11/1/17 subsequent report alleged the SS had a broken ankle and the SM refused treatment.

Report Determination: Indicated | **Date of Determination:** 11/23/2017

Basis for Determination:
On 11/23/17, ACS substantiated the allegations of IG and LMC of the SC by the SM on the basis the SM failed to ensure the SC had the necessary equipment for the SC's diagnosis and the SC's health was placed at risk. The SM admitted she was unable to monitor the SC as she ran out of test items the night before the SC's hospitalization. The medical staff reported the SM's non-compliance with monitoring the SC's diagnosis resulted in the SC's significant number of hospitalizations which placed the SC at risk of death.

The allegations of IG and LMC were unsubstantiated for the seven-year-old SS by the SM on the basis there was no concern regarding the SS ankle.

OCFS Review Results:
ACS made face-to-face contact with the subject and children, obtained information from medical professionals and relatives pertaining to the allegations and provided the SM a notification of the report. The school attendance database was reviewed. ACS completed the DV protocol and requested necessary consultations.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
ACS did not enter progress notes contemporaneously, including a late progress note dated 10/4/17 that was entered on 11/21/17, and notes dated 10/3/17 and 11/20/17 were not clearly documented.

Legal Reference:
18 NYCRR 428.5(a) and (c)

Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The SC received medical treatment and a CSC was held during the 7-Day assessment period. ACS was knowledgeable of the SC's medication schedule. ACS did not adequately or timely assess the SC's treatment plan during the school hours. During ACS initial 10/16/17 school contact it was discovered the school was unaware of the SC's medical condition and her need for close monitoring.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

During the investigation, the ACS collateral contact and discussion with the PPRS agency regarding the family's service plan was not documented in the progress notes.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/05/2017	Deceased Child, Female, 13 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 13 Years	Mother, Female, 34 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:

The 4/5/17 SCR report alleged the 13-year-old SC was diagnosed with a pre-existing medical condition and was on several different medications. The SC's medical condition was not stabilized as a result of the SM not providing the SC with the proper diet. On several occasions, the SM left the SC alone for unknown lengths of time without a plan for the SC's medical care or treatment needs. The SM provided the SC with the medication the SC required and other medical treatment. The roles of the father and SS were unknown.

Report Determination: Unfounded | **Date of Determination:** 06/02/2017

Basis for Determination:

On 6/2/17, ACS unsubstantiated the allegations of IG and LMC of the SC by the SM on the basis that the SM sought emergency medical treatment when the SC experienced a medial crisis. The SM made a plan for a relative to care for the SC when the SM was unable to do so. The SM followed up with the Dr. when the SC was released from the hospital.

OCFS Review Results:

ACS made significant face-to-face contacts with the subject and children in their home and school. ACS made relevant collateral contacts pertaining to the allegations and provided notifications. The ACS supervisor conferenced with the CPS and provided guidance during the investigation. ACS completed the DV protocol and requested consultations. The progress notes were entered in a timely manner.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/28/2016	Sibling, Male, 6 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The 9/28/16 SCR report alleged for several weeks, the six-year-old SS displayed sexually inappropriate behavior. The SM was made aware but had not intervened. The roles of other children were unknown.

Report Determination: Unfounded | **Date of Determination:** 12/11/2016

Basis for Determination:
On 12/11/16, ACS unsubstantiated the allegations of IG of the SS by the SM on the basis there was no credible evidence to support the allegation. The SM met the SS's basic needs including supervision. The SM agreed to enroll the SS in therapy at the school to address the behavioral concerns.

OCFS Review Results:
ACS made significant face-to-face contact with the subject and children in home and school. ACS made relevant collateral contacts pertaining to the allegation and provided notification. The SC was referred to the CAC for a forensic interview. The ACS supervisor conferenced with the CPS and provided guidance during the investigation. ACS completed the DV protocol and requested consultations.

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

Issue:
Failure to provide notice of report

Summary:
The father of the SS was not provided notification of the report.

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

Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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.

[redacted]

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

The SM was known in a total of six SCR reports more than three years prior to the fatality.

Of the six SCR reports, the 3/18/15, 4/25/17 and 11/1/17 reports were merged into ongoing investigations.

The allegation themes of all the investigations were IG, LMC and EdN; namely for SM's non-compliance with following up with medical intervention for her children.

The 3/9/15 SCR report included the allegation of IG of the SC by the SM and the father of the SS. On 5/21/15, Broome County DSS unsubstantiated the allegation of the report.

The 2/23/10 SCR report included the allegation of EdN of the SC by the SM. On 3/22/10, ACS unsubstantiated the allegation as the SC had relocated out of state and transferred to another school.

The 12/15/03 SCR report included the allegations of IG and LMC of the SC by SM. On 2/12/04, ACS substantiated the allegations as the SC missed two medical appointments and the SM failed to make herself available for the investigation.

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: 05/31/2017

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 05/31/2017

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?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

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 Children's Aid Society (CAS) agency provided casework counseling, monitoring, assistance with community resources, homemaking and case management services to the family.

Required Action(s)

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

Issue:	Failure to Monitor

Summary:	ACS was ordered by the court to monitor the family; however, ACS failed to monitor the family as there were no progress notes entered by ACS from 11/8/17 through 4/10/18.
Legal Reference:	18 NYCRR 432.2(b)(5)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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

On 12/14/16, a preventive services case was opened as the family was offered services to include art therapy. The SM declined the services and the case was subsequently closed on 12/16/16.

The family had an open preventive services case at the time of the incident. During the 4/5/17 investigation, ACS opened a preventive services case on 5/31/17 as the SM accepted PPRS with Children's Aid Society (CAS) agency. The Family Court ordered ACS to supervise the family. ACS was supervising the family 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?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
10/06/2017	There was not a fact finding	There was not a disposition
Respondent:	046552 Mother Female 35 Year(s)	
Comments:	As a result of the 9/29/17 investigation, ACS filed an Article Ten Neglect petition in Bronx County Family Court on behalf of all the children on 10/6/17. The court ordered the release of the children to the SM with ACS supervision.	

Have any Orders of Protection been issued? Yes	
From: 07/14/2016	**To:** 07/14/2017
Explain: The LE database revealed an order of protection was issued for the SM against the father of the SS.	
From: 09/25/2015	**To:** 03/15/2016
Explain: The LE database revealed an order of protection was issued for the SM against the father of the SS.	

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