



**Report Identification Number: NY-22-054**

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

**Issue Date: Dec 20, 2022**

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

- A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
- The death of a child for whom child protective services has an open case.
- The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
- The death of a child for whom the local department of social services has an open preventive service case.

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

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

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

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

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

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



## Abbreviations

<b>Relationships</b>		
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	
<b>Contacts</b>		
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	DA-District Attorney	
<b>Allegations</b>		
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	SXTF-Sex Trafficking
<b>Miscellaneous</b>		
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:** 6 month(s)

**Jurisdiction:** Kings  
**Gender:** Male

**Date of Death:** 07/04/2022  
**Initial Date OCFS Notified:** 07/05/2022

## Presenting Information

The New York City Administration for Children's Services (ACS) completed an OCFS-7065 Agency Reporting Form, after learning of the subject child's death, which occurred on 7/4/22.

## Executive Summary

On 7/5/22, ACS was informed of the death of the subject child which occurred on 7/4/22. There was an open preventive services case at the time of the death due to subject child being diagnosed with cardiogenic shock and experiencing a hypoxic brain injury with multi-organ dysfunction that left him hospitalized and medically fragile. At the time of his death, the subject child resided with his mother and two siblings, ages 2 and 9-years-old. The father of the subject child resided with the paternal grandmother at a different residence.

ACS learned that the mother brought the subject child to the hospital on 7/4/22 due to concern about a cough that persisted for approximately two weeks after the subject child received routine immunizations. The subject child was discharged from the hospital in the early morning hours of 7/4/22, with no recommendation for follow-up care. Around 8:00AM, the mother noticed the subject child was unresponsive and contacted emergency medical services. The subject child was brought to the hospital where he was pronounced deceased at 8:43AM.

An autopsy was performed, and the medical investigator noted the cause of death to be undetermined; however, testing of the subject child's blood and tissue samples were pending. It was determined that the subject child's death was not a result of abuse or maltreatment, and therefore an SCR report was not registered related to the death.

Bereavement services were discussed and offered to the mother. The mother was initially engaged with mental health services but did not feel they were beneficial and was in the process of reengaging in services to address her ongoing mental health and grief. The surviving siblings were deemed to be safe in the mother's care. The 9-year-old sibling expressed throughout the case that she did not want to speak with anyone other than the mother about the subject child's death; however, the mother was actively trying to get the sibling engaged in services through her school or family therapy through the mother's service provider. The preventive services case record did not reflect attempts to speak with or offer services to the subject child's father.

### PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

## Findings Related to the CPS Investigation of the Fatality

### Safety Assessment:

- Was sufficient information gathered to make the decision recorded on the:



- Safety assessment due at the time of determination? N/A

**Determination:**

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

**Explain:**

This was not an SCR-reported fatality and therefore no determination was made.

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

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

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

**Explain:**

The record does not reflect that the SC's father was contacted or offered services despite being listed as a recipient of services.

### 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: 07/04/2022

Time of Death: 08:43 AM

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: 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

Total number of deaths at incident event:

Children ages 0-18: 1



Adults: 0

### Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	6 Month(s)
Deceased Child's Household	Mother	No Role	Female	31 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Other Household 1	Father	No Role	Male	42 Year(s)

### LDSS Response

After learning of the SC's death, ACS notified the New York City Regional Office, spoke with the SM, and conducted a home visit to assess the safety of the SSs.

The SM reported that she first brought the SC to the hospital on 6/24/22 after the SC had received his 4-month immunizations and developed a persistent, dry cough. The SM was advised to let the cough "run its course" and was discharged with saline nose drops for the SC. The SM was still concerned about the SC's condition due to him being medically fragile and made a follow up appointment with the pediatrician for 7/6/22. The SM brought the SC back to the hospital for the cough on 7/4/22, and was discharged again in the early hours of the same day. The SM noticed around 8:00AM on 7/4/22 that the SC continued to cough, appeared to lose his voice, and became unresponsive. The SM contacted EMS who attempted life-saving measures, while transporting the SC to the hospital. The SC was later pronounced deceased at the hospital.

The SC was diagnosed with fetal cardiac issue while in utero and the SM was advised this would need to be monitored after birth. The SM reported the SC had an elevated heart rate at birth but that this resolved, and the SC was discharged with her with minimal explanation as to what follow-up medical care would be required. In February 2022, the SC went into cardiogenic shock with multi-organ dysfunction and experienced a hypoxic brain injury which resulted in the SC being hospitalized and undergoing heart surgery. The SC required extensive medical care following his discharge from the hospital and the preventive services case was opened to assist the SM in meeting the SC's medical needs. At the time of the SC's death, the SM had been compliant with attending to the medical needs of the SC.

The preventive service case remained opened at the time of this writing, and an agency contracted by ACS continued to provide services to the SM and SSs to address ongoing mental health and grief.

### Official Manner and Cause of Death

**Official Manner:** Undetermined

**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 referred to an OCFS approved Child Fatality Review Team?**No

**Comments:** ACS does not have an OCFS approved Child Fatality Review Team.



### CPS Fatality Casework/Investigative Activities

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

**Additional information:**

Although this was not an SCR-reported fatality, ACS did contact collateral sources throughout the case.

### Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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**Explain:**

While the safety of the SSs was assessed throughout the case; this was a non-SCR reported fatality and therefore the Safety Assessment Tool was not required.

### Fatality Risk Assessment / Risk Assessment Profile



# Child Fatality Report

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Explain:**

This was not an SCR-reported fatality and therefore the Risk Assessment Profile was not required.

### 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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



<b>Family planning</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Homemaking Services</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Parenting Skills</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Domestic Violence Services</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Early Intervention</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Alcohol/Substance abuse</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Child Care</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Intensive case management</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Family or others as safety resources</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Other</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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:**  
Grief services were offered on behalf of the 9yo SS. The 9yo SS expressed throughout the case that she did not want to talk to anyone other than the SM about the SC's death, though the SM was actively trying to get the SS in counseling through her school or family counseling.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes**

**Explain:**  
Bereavement services were offered to the mother, in addition to mental health counseling. The SM had previously engaged in counseling but felt it was not beneficial and stopped attending. After the SC passed away, the SM recognized the need for counseling services and agreed to reengage with services. The SM had completed an additional MH intake appointment with a different agency she felt might be more beneficial.

## History Prior to the Fatality

### Child Information

- Did the child have a history of alleged child abuse/maltreatment?** 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?** Yes

### Infants Under One Year Old

**During pregnancy, mother:**

- Had medical complications / infections
- Misused over-the-counter or prescription drugs
- Experienced domestic violence
- Was not noted in the case record to have any of the issues listed
- Had heavy alcohol use
- Smoked tobacco
- Used illicit drugs



**Infant was born:**

Drug exposed

With fetal alcohol effects or syndrome

With neither of the issues listed noted in case record

## 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)
02/17/2022	Deceased Child, Male, 1 Months	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 1 Months	Mother, Female, 31 Years	Lack of Medical Care	Unsubstantiated	

**Report Summary:**

The SCR report alleged when the SM was pregnant with the SC, she was told the SC had fetal cardiac issues and would need to be closely monitored by a specialist during the pregnancy. The SM saw the specialist once and missed multiple recommended appointments to monitor the SC's heart function and development. After the SC's birth, the SM failed to follow up with a pediatrician. On 2/9/22, the SC suffered cardiogenic shock and was hospitalized in critical condition with multi-organ system dysfunction. The SC experienced hypoxic brain injury, seizures, and permanent brain damage. The severity of the SC's medical condition could have been prevented if the SM followed through with medical care.

**Report Determination:** Unfounded

**Date of Determination:** 04/17/2022

**Basis for Determination:**

ACS determined there was no credible evidence to substantiate the allegations of IG and LMC against the SM. The SM took appropriate action and sought out emergency medical attention when she noticed the SC was not moving. The SM insisted EMS transport the SC to the hospital even though EMS had stated the SC appeared well. The SM was deemed to be a suitable caregiver for the SC and ACS noted the mother's actions did not place the SC at risk of harm.

**OCFS Review Results:**

ACS initiated their investigation within 24-hours, assessed the safety of all children, and interviewed the SM regarding the allegations. ACS contacted appropriate collateral sources and was in regular contact with medical personnel regarding the SC's medical status. ACS completed a home visit to the MA's residence where the SSs were staying while the SC was hospitalized and a home visit to the case address after the SC's discharge from the hospital. A face-to-face interview and home visit to the father's residence were not documented.

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

**Issue:**

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

**Summary:**

Though ACS interviewed the father via phone, the record did not reflect that a face-to-face interview was attempted. A home visit to the father's residence was not documented, despite the then 1yo SS regularly visiting that residence.

**Legal Reference:**

18 NYCRR 432.1 (o)

**Action:**

ACS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.



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

There was no CPS investigative history more than three years prior to the fatality.

### Known CPS History Outside of NYS

There is no known 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: 03/16/2022

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the services provided meet the service needs as outlined in the case record?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did all service providers comply with mandated reporter requirements?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Services Provided

	Yes	No	N/A	Unable to Determine
Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Family Assessment and Service Plan (FASP)



# Child Fatality Report

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Additional information, if necessary:**  
 A community agency contracted by ACS provided preventive services to the family.

### Required Action(s)

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

Yes  No

<b>Issue:</b>	Adequacy of Child Protective Services casework contacts (open services)
<b>Summary:</b>	The preventive case record did not reflect any contact with the SC's father prior to or following the SC's death, and there was no documentation that services were discussed with or offered to him despite being listed as a recipient of services.
<b>Legal Reference:</b>	18 NYCRR 432.2(b)(4)(vi)
<b>Action:</b>	In cases where the child protective service is the primary service provider to children named in indicated child protective services cases and their families, ACS must make at least two separate face-to-face contacts per month with the subject(s) and other persons named in the report, one of which one must take place in the subject's home.

### Preventive Services History

A preventive services case was opened on 3/16/22 to provide additional support in addressing the SM's mental health and meeting the medical needs of the SC after he experienced a hypoxic brain injury, was hospitalized, and required extensive medical care. The case remained open following the SC's death to address the SM's ongoing mental health.

### 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.

### 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