NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-14-125 **Prepared by: New York City Regional Office**

Issue Date: 5/26/2015

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	MN-Medical Neglect	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 11/14/2014
Initial Date OCFS Notified: 11/20/2014

Presenting Information

On 11/20/14, the SCR registered a report alleging that on 11/13/14, the stepfather (SF) violently shook the 2-year-old SC for unknown reasons. As a result, the SC became unresponsive. The BM called 911 for EMS and the SC was taken to the hospital where she was immediately placed on life support. Medical examinations revealed that the SC suffered a subdural hemorrhage. The SF was interviewed by the NYPD and arrested after he admitted to shaking the SC. The SC was taken off the life support on 11/20/14 and pronounced dead.

Executive Summary

The SC was two years old at the time of her death. She sustained subdural hemorrhages to the brain with severe swelling. ACS has not yet received the autopsy report; however, the ME has ruled the death as a homicide.

On 11/13/14 at 5:00 A.M., the BM found the SC was having difficulty breathing, but delayed calling 911 until 6:39 A.M. EMS found the SC was unresponsive, and with bruising to the upper abdominal area, inner thighs and upper left shoulder. She had urinated on herself and was fully dressed. EMS administered CPR and transported the SC to the hospital where she was placed on life support.

A CAT-Scan revealed that the SC had severe hemorrhaging in the brain and no neurological functioning. The BM reported that another child at the park kicked the SC on the head on 11/11/14. This explanation was not plausible due to the severity of the injuries. The SC had other injuries for which the physician could not provide a timeline.

The NYPD questioned the SF and the BM. The SF admitted that he forcefully shook the SC on Wednesday, 11/12/14. The mother was at an appointment when the incident occurred. The SF was arrested on 11/13/14 and charged with the murder of the SC. The NYPD did not obtain information to incriminate the BM in this incident. The SF is currently incarcerated.

The BM reported to the NYPD that when she returned to the home on 11/12/14 the SC was lying on the bed and she pulled the SC by the arm; the SC did not respond. The BM took the SC over her shoulder and carried her out of the room. At some point, the SC sat up in a car seat and later became responsive but refused to eat. The SC laid on the couch and fell asleep. The BM said she checked the SC in the middle of the night and she was breathing, but at 5:00 A.M., the SC was not breathing. ACS did not ask about the reason for the delay in calling 911.

The NYPD initially asked ACS not to interview the SF or BM and the home was deemed a crime scene. ACS made no effort to interview the SF throughout the investigation.

ACS interviewed the BM on 12/11/14 at her grandmother's home; however did not ascertain a timeline for the events leading up to the EMS call or what caused the delay in calling 911.

The BM said the SC was lying on her bed when she returned from her appointment and appeared to be asleep. An hour later, the BM checked the SC and saw the SC was awake, but remained in bed. The BM carried the SC to the living room but when she went to put the SC down the SC would not stand up. Therefore, she placed the SC in the

car seat and the SC sat up. The SC refused to eat and fell asleep on the sofa. The BM's bed was located in living room and the sofa was located across from the BM's bed. The BM said she awoke on 11/13/14 and heard the SC struggling to breath. The BM said that she awoke the SF who attempted to administer CPR while she called 911.

The SC was pronounced dead on 11/14/14 at 7:30 P.M., but was taken off life support on 11/20/2014.

On 12/19/2014, the BM gave birth to a premature infant. ACS filed an Article 10 Petition of Abuse against BM and the SF (BF of the newborn). The judge granted a remand and once the infant was discharged from the hospital on 1/5/2015, she was placed into non-kinship foster care.

ACS interviewed the SF's two children from a previous relationship and their BM. The children had observed their BF hit the SC and the SC's BM take the SC to the bathroom to hit her with a belt. The children denied being hit by their BF or the SC's BM.

On 4/9/15, ACS SUB the allegations of DOA, II, CTS and IG against the SF citing the SC's injuries and his admission to forcefully shaking the SC. The allegation of IG was SUB against the BM due to her failure to seek immediate medical attention.

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?** N/A
  - **Safety assessment due at the time of determination?** 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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
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:
N/A

Required Actions Related to the Fatality

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

Issue:	Provision of Notice of Indication
Summary:	Notice of Indication was not issued for the BM or SF who were the subjects of the report nor the BF.
Legal Reference:	18 NYCRR 432.2(f)(xi)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriateness of allegation determination
Summary:	The investigation revealed that the allegation of EXCP should have been added and substantiated for the mother. In addition, the allegations the mother's failure to protect the SC contributed to the II, CTS and DOA/Fatality.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 7 Day safety was not completed properly. Safety decision # 2 was selected yet there were no surviving siblings at the time. There was no modification safety assessment completed once the sibling was born and placed in foster care.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Failure to provide notice of report
Summary:	The Notice of Existence was not issued for the BF.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30 Day Report was not completed timely and was approved on 3/10/15.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Face-to-Face Interview (Subject/Family)
Summary:	ACS made no attempt to interview the SF after the initial arrest. ACS made collateral contact with relatives to find a resource for the newborn, but did not inquire about the BM and/or SF's relationship with the SC.

Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/14/2014 **Time of Death:** 19:30 PM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 30 Minutes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Stepfather	Alleged Perpetrator	Male	25 Year(s)

LDSS Response

The SC was two years old at the time of her death. She sustained subdural hemorrhages to the brain with severe swelling. ACS has not received the autopsy report; however, the ME has ruled the death a homicide.

On 11/13/14 at 5:00 A.M., the BM noticed the SC having difficulty breathing, but delayed calling 911 until 6:39 A.M.EMS found the SC unresponsive, with bruising to the upper abdominal area, inner thighs and upper left shoulder. EMS administered CPR and transported the SC to the hospital where she was placed on life support. A CAT-Scan revealed that the SC had severe hemorrhaging in the brain and no neurological functioning. The BM reported another child at the park kicked the SC on the head on 11/11/14. This explanation was not plausible due to the severity of the injuries. The SC had other injuries for which the physician could not provide a timeline.

On 11/13/14, the NYPD questioned the SF and the BM. The SF admitted that he forcefully shook the SC on Wednesday, 11/12/14. The SF said the SC urinated on herself and he heard the BM tell the SC to sit on the potty several times. The SF said that after the third time, he yelled out and told the SC to stay on her potty. The BM prepared to go to an appointment, but told the SF that she was not taking the SC because the SC did not deserve to go. According to the SF, after the BM left, the SC fell off her potty and was lying flat on the ground. He attempted to pick up the SC but she had "stiffened up." He became frustrated because the SC would not "loosen up." He then attempted to "bend" the SC arms and legs to get her to stand up to no avail. He then placed the SC in the bathtub and ran cold water on the SC and she began flopping around but did respond. The SF said he sat the SC and she fell back and hit her head in the tub. He tried again, but this time he prevented her from hitting her head. The SF then took the SC out of the tub and stood her up outside the tub. He forcibly shook the SC and yelled at her asking whether she wanted "the people to take her away" due to her behavior. The SF said that when he let the SC go, she fell a second time on the bathroom floor. The SF said that he picked up the SC and placed her on the bed. The SF was arrested and charged with the murder of the SC. ACS did not ask the NYPD whether the SF had shared any of this information with the BM. ACS did not attempt to interview the SF after his arrest.

ACS interviewed the BM on 12/11/14 at the MGM's home but did not obtain a timeline for all events leading up to the 911 call or the reason for the delay in calling EMS. Her account was consistent with the information ACS obtained from the NYPD. The BM said the SC was lying on the bed when she returned to the home on 4/12/14 and appeared to be asleep. An hour later, the BM checked the SC and noticed the SC was awake in bed. The BM carried the SC to the living room but the SC would not stand up on her own. The BM placed the SC in the car seat and the SC sat up. The SC refused to eat and fell asleep on the sofa. The BM's bed was located in the living room and the sofa where the SC laid was located across from the BM's bed. The BM awoke at 5:00 A.M., on 11/13/14 and heard the SC struggling to breath. The BM awoke the SF who administered CPR while she called 911. EMS responded and transported the SC to the hospital where she was placed on life support.The SC was pronounced dead on 11/14/14 at 7:30 P.M.

ACS interviewed the SF's two children from a previous relationship and their BM. The children had observed their BF and the SC's BM hit the SC.

On 12/19/2014, the BM gave birth. ACS filed an Article 10 Neglect Petition and the infant was remanded and placed into a non-kinship foster home.

On 4/9/15, ACS SUB the allegations of DOA, II, CTS and IG against the SF citing the SC's injuries and his admission to forcefully shaking the SC. The allegation of IG was SUB against the BM due to her failure to immediately seek medical attention.

Official Manner and Cause of Death

Official Manner: Homicide

Primary Cause of Death: From an injury - external 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 previously approved protocols for joint investigations.

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 NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
012761 - Deceased Child, Female, 2 Yrs	012762 - Stepfather, Male, 25 Year(s)	DOA / Fatality	Substantiated
012761 - Deceased Child, Female, 2 Yrs	012762 - Stepfather, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
012761 - Deceased Child, Female, 2 Yrs	016121 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
012761 - Deceased Child, Female, 2 Yrs	012762 - Stepfather, Male, 25 Year(s)	Choking / Twisting / Shaking	Substantiated
012761 - Deceased Child, Female, 2 Yrs	012762 - Stepfather, Male, 25 Year(s)	Internal Injuries	Substantiated

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:
There was no visit to the case address. ACS interviewed and visited the home of the SF's children. They were deemed safe.
21 - The BM was interviewed; but, there was no effort to interview the SF after his initial arrest.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a	☒	☐	☐	☐

petition in Family Court at any time during or after the investigation?				
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed and placed in foster care at any time during this fatality investigation?	☒	☐	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
There was no surviving sibling at the time of the child's death; however, the mother who was pregnant gave birth to a female child on 12/19/14 - more than 30 days after the investigation had begun.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
03/25/2015	Step father	Pending	Pending
Comments:	The stepfather was initially arrested on 11/13/14 after he admitted to shaking the SC. A $200,000 bail was ordered and he posted bond on 3/24/15. However, he was rearrested on 3/25/15 and charged with a class A Felony Murder in regard to the child.		

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐

Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☒	☐	☐	☐	☐	☐	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☒	☐	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☒	☐	☐	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: N/A							

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:
Although there were no other children in the home at the time of the SC's death, the BM was pregnant and gave birth on 12/19/14. An Article 10 Petition was filed naming the SF (BF of the sibling) and the BM on behalf on the newborn sibling. The sibling was remanded and placed in the custody of the Commissioner of ACS.

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? N/A
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/29/2014	643-Deceased Child,Female, 2 Years	642-Stepfather,Male, 25 Years	Inadequate Guardianship	Indicated	Yes
	643-Deceased Child,Female, 2 Years	641-Mother,Female, 25 Years	Inadequate Guardianship	Unfounded	
	643-Deceased Child,Female, 2 Years	641-Mother,Female, 25 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:
The report alleged that the BM was physically violent towards the SC for unknown reasons. It noted that the SC had visible marks to her wrist, shoulder and back as a result of the inflicted beatings.

On 9/7/14, the SCR registered a report alleging that the mother hit the SC in the face on or about 9/5/14. It was noted that the SC had a cut lip and a bruised nose. This report was merged due to similar allegations.

Determination: Indicated | **Date of Determination:** 09/26/2014

Basis for Determination:
ACS unsubstantiated IG against the BM citing that there was no credible against her. ACS also cited that the BM provided a minimal degree of care for the SC. ACS substantiated the allegation against the SF citing that the subsequent report was registered with similar allegations and the SC was in the home in the care of SF at the time of the incident. .

OCFS Review Results:
The SF and BM gave inconsistent accounts; the building cameras revealed that the SC was injured in the home. The SF later admitted that SC injured her nose and upper lip when she fell in the home while he was getting her dressed. The injury to her leg was sustained when the SC fell off her bed.

The SC was interviewed and examined at the CAC. SC denied that she had been “physically disciplined.” The doctor who completed the assessment could not determine whether the SC's injuries were inflicted. A CSC was held and as a result, ACS referred the family to preventive services for parenting and family counseling services. ACS did not seek court intervention.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
ACS completed two 7 Day Safety assessments. The safety decisions did not reflect the urgency in this case.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Assessment as to need for Family Court Action
Summary:
Although the SC denied the allegations at the CAC; it was confirmed that the SF lied about the manner in which the SC

sustained the injuries on her face. The BF also expressed his suspicion about the SC's injuries.

Legal Reference:

18 NYCRR 432.2(b)(3)(vi)

Action:

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

Issue:

Failure to provide notice of report

Summary:

a NOE was not issued for the BF.

Legal Reference:

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

Action:

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

Issue:

Provision of Notice of Indication

Summary:

There was no NOI issued to the SC’s BF who had been interested in obtaining custody of the SC. In addition, there was no NOI issued for the BM.

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/13/2014	2402 - Deceased Child, Female, 2 Years	2392 - Mother, Female, 25 Years	Lacerations / Bruises / Welts	Unfounded	Yes
	2402 - Deceased Child, Female, 2 Years	2393 - Stepfather, Male, 25 Years	Choking / Twisting / Shaking	Indicated	
	2402 - Deceased Child, Female, 2 Years	2393 - Stepfather, Male, 25 Years	Inadequate Guardianship	Indicated	
	2402 - Deceased Child, Female, 2 Years	2393 - Stepfather, Male, 25 Years	Internal Injuries	Indicated	
	2402 - Deceased Child, Female, 2 Years	2393 - Stepfather, Male, 25 Years	Lacerations / Bruises / Welts	Indicated	
	2402 - Deceased Child, Female, 2 Years	2393 - Stepfather, Male, 25 Years	Lack of Medical Care	Indicated	
	2402 - Deceased Child, Female, 2 Years	2393 - Stepfather, Male, 25 Years	Swelling / Dislocations / Sprains	Indicated	

2402 - Deceased Child, Female, 2 Years	2392 - Mother, Female, 25 Years	Choking / Twisting / Shaking	Unfounded
2402 - Deceased Child, Female, 2 Years	2392 - Mother, Female, 25 Years	Inadequate Guardianship	Indicated
2402 - Deceased Child, Female, 2 Years	2392 - Mother, Female, 25 Years	Internal Injuries	Unfounded
2402 - Deceased Child, Female, 2 Years	2392 - Mother, Female, 25 Years	Lack of Medical Care	Indicated
2402 - Deceased Child, Female, 2 Years	2392 - Mother, Female, 25 Years	Swelling / Dislocations / Sprains	Unfounded

Report Summary:
The report alleged that the SC suffered severe trauma to the head and body that suggested she was violently shaken. The SC had bruising to her lower chest and upper abdomen, bruising to an upper extremity, two bleeds on her brain that caused it to push her brain over to one side of her head. The SC was reported to be in critical condition. The report noted that the SC was in the care of the mother. ACS added the SF as a subject to this report.

This report was registered at 10:33 A.M.

Determination: Indicated | **Date of Determination:** 04/09/2015

Basis for Determination:
ACS SUB the allegations of IG and LMED against the SF and the BM citing that they failed to meet a minimum standard of care and failed to seek medical care after the SC was in distress. ACS also SUB LBW, II, CTS and SDS citing the SF's admission to shaking the SC, internal injuries and the bruises the SC sustained.

ACS UNSUB allegations of LBW, CTS, SDS and II against the BM citing the SF's admission to shaking the SC and the fact that there was no credible evidence to SUB these allegations against the BM.

OCFS Review Results:
The investigation revealed that the trigger for this incident was due to the BM's frustration with the SC not being toilet trained. The BM left the SC with the SF knowing that he was yelling at her so that she would sit on the "potty" and the fact that he had recently lied about the manner in which the SC had sustained bruises on her face. The SF had two children from a former relationship who visited their father (SF to SC) and reportedly they had observe the BM "beat" the SC and SF hit the SC. It seems that the BM might have been physically abusive to the SC as she also lied to the medical staff in the ER and delayed calling EMS.

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

Issue:
Failure to provide notice of report
Summary:
The NOE was not issued for the BF.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:

The SF was arrested at the inception of the investigation and ACS was not allowed to interview him. However, the documentation does not reflect that ACS attempted to contact his attorney or interview him at Riker's Island where he was incarcerated.

Legal Reference:

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

Action:

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7 Day safety assessment was not properly completed the safety decision should have been no safety factors as it was completed on 11/20/14 and the SC was declared brain dead on 11/14/14. The SC had no siblings at that time.

Legal Reference:

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

Action:

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

Issue:

Provision of Notice of Indication

Summary:

No NOI was issued for the BM, SF or BF.

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/13/2014	2421 - Deceased Child, Female, 2 Years	2423 - Stepfather, Male, 25 Years	Choking / Twisting / Shaking	Indicated	Yes
	2421 - Deceased Child, Female, 2 Years	2423 - Stepfather, Male, 25 Years	Lacerations / Bruises / Welts	Indicated	
	2421 - Deceased Child, Female, 2 Years	2423 - Stepfather, Male, 25 Years	Lack of Medical Care	Indicated	
	2421 - Deceased Child, Female, 2 Years	2425 - Mother, Female, 25 Years	Choking / Twisting / Shaking	Unfounded	
	2421 - Deceased Child, Female, 2 Years	2425 - Mother, Female, 25 Years	Inadequate Guardianship	Indicated	
	2421 - Deceased Child, Female, 2 Years	2425 - Mother, Female, 25 Years	Internal Injuries	Unfounded	

2421 - Deceased Child, Female, 2 Years	2425 - Mother, Female, 25 Years	Lacerations / Bruises / Welts	Unfounded
2421 - Deceased Child, Female, 2 Years	2425 - Mother, Female, 25 Years	Lack of Medical Care	Indicated
2421 - Deceased Child, Female, 2 Years	2425 - Mother, Female, 25 Years	Swelling / Dislocations / Sprains	Unfounded
2421 - Deceased Child, Female, 2 Years	2423 - Stepfather, Male, 25 Years	Inadequate Guardianship	Indicated
2421 - Deceased Child, Female, 2 Years	2423 - Stepfather, Male, 25 Years	Internal Injuries	Indicated
2421 - Deceased Child, Female, 2 Years	2423 - Stepfather, Male, 25 Years	Swelling / Dislocations / Sprains	Indicated

Report Summary:
The report alleged that at 6:00 A.M. the BM discovered the SC was having difficulty breathing, but delayed calling 911. EMS arrived at 6:40 A.M. and found the SC apneic, unresponsive and in respiratory distress. The SC had bruises on her upper abdominal area and both inner thighs that appeared inflicted. It was noted that the SC had urinated on herself and was fully dressed when EMS arrived. The report alleged that the respiratory distress and bruising was the result of child abuse and that the SC was in critical condition.

This report was registered at 10:23 A.M. ACS added the SF to the report.

Determination: Indicated **Date of Determination:** 04/09/2015

Basis for Determination:
Allegations of CTS, II, LBW & SDS were SUB against the SF due to his admission to shaking the SC forcefully; which caused hemorrhaging to the brain and subsequent death. The SC was also seen with bruises on her body. These allegations were UNSUB against the BM noting there was no credible evidence against her. There was no consideration of the information provided by the SF's children who witnessed the BM hit the SC with a belt.

The allegations of LMED and IG were SUB for the SF and the BM for the delay in seeking medical attention. ACS also cited they failed to meet a minimum standard of care for the SC.

OCFS Review Results:
The investigation revealed that the trigger for this incident was due to the BM's frustration with the SC not being toilet trained. The BM left the SC with the SF knowing that he was yelling at her so that she would sit on the "potty" and the fact that he had recently lied about the manner in which the SC had sustained bruises on her face. The SF's two children from a former relationship reported they had observe the BM "beat" the SC and SF hit the SC. It seems that the BM might have been physically abusive to the SC as she also lied to the medical staff in the ER and delayed calling EMS.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7 Day safety assessment was not properly completed. The SC was declared brain dead on 11/14/14; which the doctor inform ACS would be the date of death listed on the safety assessment. There were not surviving siblings. The sibling was born on 12/19/14 and no modification safety assessment was completed.

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

Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who

attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to provide notice of report
Summary:
There was no NOE issued for the BF.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
The BM and the SF were the subjects of this report. The NYPD initially ask that neither the BM or the SF be interviewed. ACS later interviewed the BM, but did not attempt to interview the SF at the correctional facility. There was no effort to contact the SF's attorney.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Provision of Notice of Indication
Summary:
No NOI was issued for the BM, SF or BF.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/13/2014	2441 - Deceased Child, Female, 2 Years	2442 - Mother, Female, 25 Years	Choking / Twisting / Shaking	Unfounded	Yes
	2441 - Deceased Child, Female, 2 Years	2442 - Mother, Female, 25 Years	Inadequate Guardianship	Indicated	
	2441 - Deceased Child, Female, 2 Years	2442 - Mother, Female, 25 Years	Internal Injuries	Unfounded	
	2441 - Deceased Child, Female, 2 Years	2442 - Mother, Female, 25 Years	Lacerations / Bruises / Welts	Unfounded	

2441 - Deceased Child, Female, 2 Years	2442 - Mother, Female, 25 Years	Lack of Medical Care	Indicated
2441 - Deceased Child, Female, 2 Years	2442 - Mother, Female, 25 Years	Swelling / Dislocations / Sprains	Unfounded
2441 - Deceased Child, Female, 2 Years	2444 - Stepfather, Male, 25 Years	Choking / Twisting / Shaking	Indicated
2441 - Deceased Child, Female, 2 Years	2444 - Stepfather, Male, 25 Years	Inadequate Guardianship	Indicated
2441 - Deceased Child, Female, 2 Years	2444 - Stepfather, Male, 25 Years	Internal Injuries	Indicated
2441 - Deceased Child, Female, 2 Years	2444 - Stepfather, Male, 25 Years	Lacerations / Bruises / Welts	Indicated
2441 - Deceased Child, Female, 2 Years	2444 - Stepfather, Male, 25 Years	Lack of Medical Care	Indicated
2441 - Deceased Child, Female, 2 Years	2444 - Stepfather, Male, 25 Years	Swelling / Dislocations / Sprains	Indicated

Report Summary:
The report noted that the SC had severe hemorrhaging in the brain, was unresponsive and had no neurological functioning. The report noted that the SC was healthy and the explanation provided for the injuries were inconsistent. The report also noted that the SC is only cared for by the SF and BM.

This report was registered @ 10:30 A.M.

Determination: Indicated | **Date of Determination:** 04/09/2015

Basis for Determination:
ACS SUB the allegations of II, LBW, CTS & DSD against the SF due to his admission of forcefully shaking the SC which lead to her injuries. ACS SUB the allegations of LMED and IG against the BM and SF due to their failure to seek immediate medical attention when the SC showed signs of distress.

ACS UNSUB the allegations of CTS, II, SDS and LBW against the BM based on the SF's admission to forcefully shaking the SC. ACS noted that there was no credible evidence against the BM. ACS did not take into consideration the BM's failure to protect the SC, the BF's suspicions and the SF's children's accounts noting that the BM would hit the SC with a belt.

OCFS Review Results:
The investigation revealed that the trigger for this incident was due to the BM's frustration with the SC not being toilet trained. The BM left the SC with the SF knowing that he was yelling at her so that she would sit on the "potty" and the fact that he had recently lied about the manner in which the SC had sustained bruises on her face (July and Sept incidents). The SF's two children from a former relationship reported they had observe the BM "beat" the SC and SF hit the SC. It seems that the BM might have been physically abusive to the SC as she also lied to the medical staff in the ER and delayed calling EMS.

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

Issue:
Failure to provide notice of report

Summary:
NOE not issued for the BF.

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

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The safety assessment was timely; however, the safety decision was incorrect as there were no surviving sibling at the time. The sibling was born on 12/19/14 and a modification safety assessment was completed.

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

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

Issue:
Appropriateness of allegation determination

Summary:
The allegations for the BM were not properly explored as she failed to protect the SC from the SF and was aware from the July and September incidents that he had lied about the SC's injuries. There was also some credible evidence to support that both the SF and BM used EXCP.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

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

Issue:
A child was born during an open CPS investigation and never added to the report

Summary:
The sibling was born and never added to the family composition in this report even though ACS filed an Article 10 Petition for this child and she was remanded to the custody of the Commissioner of ACS.

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

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

Issue:
Provision of Notice of Indication

Summary:
No NOI was issued for the BM, SF or BF.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/13/2014	2471 - Deceased Child, Female, 2 Years	2472 - Mother, Female, 25 Years	Choking / Twisting / Shaking	Unfounded	Yes
	2471 - Deceased Child, Female, 2 Years	2472 - Mother, Female, 25 Years	Inadequate Guardianship	Indicated	
	2471 - Deceased Child, Female, 2 Years	2472 - Mother, Female, 25 Years	Internal Injuries	Unfounded	
	2471 - Deceased Child, Female, 2 Years	2472 - Mother, Female, 25 Years	Lacerations / Bruises / Welts	Unfounded	
	2471 - Deceased Child, Female, 2 Years	2472 - Mother, Female, 25 Years	Lack of Medical Care	Indicated	
	2471 - Deceased Child, Female, 2 Years	2472 - Mother, Female, 25 Years	Swelling / Dislocations / Sprains	Unfounded	
	2471 - Deceased Child, Female, 2 Years	2473 - Stepfather, Male, 25 Years	Choking / Twisting / Shaking	Indicated	
	2471 - Deceased Child, Female, 2 Years	2473 - Stepfather, Male, 25 Years	Inadequate Guardianship	Indicated	
	2471 - Deceased Child, Female, 2 Years	2473 - Stepfather, Male, 25 Years	Internal Injuries	Indicated	
	2471 - Deceased Child, Female, 2 Years	2473 - Stepfather, Male, 25 Years	Lacerations / Bruises / Welts	Indicated	
	2471 - Deceased Child, Female, 2 Years	2473 - Stepfather, Male, 25 Years	Lack of Medical Care	Indicated	
	2471 - Deceased Child, Female, 2 Years	2473 - Stepfather, Male, 25 Years	Swelling / Dislocations / Sprains	Indicated	

Report Summary:
The report noted that the SC had two bleeding on the brain and bruises around her chest and abdomen area. The SC also experience difficulty breathing. There was no explanation provided as to how the SC sustained the injuries and the situation appeared suspicious.

Determination: Indicated **Date of Determination:** 04/09/2015

Basis for Determination:
Allegations of CTS, II, LBW & SDS were SUB against the SF due to his admission to shaking the SC forcefully; which caused hemorrhaging to the brain and subsequent death. The SC was also seen with bruises on her body. These allegations were UNSUB against the BM noting there was no credible evidence against her. There was no consideration of the information provided by the SF's children who witnessed the BM hit the SC with a belt.

The allegations of LMED and IG were SUB for the SF and the BM for the delay in seeking medical attention. ACS also cited they failed to meet a minimum standard of care for the SC.

OCFS Review Results:
The investigation revealed that the trigger for this incident was due to the BM's frustration with the SC not being toilet

trained. The BM left the SC with the SF knowing that he was yelling at her so that she would sit on the "potty" and the fact that he had recently lied about the manner in which the SC had sustained bruises on her face. The SF's two children from a former relationship reported they had observe the BM "beat" the SC and SF hit the SC. It seems that the BM might have been physically abusive to the SC as she also lied to the medical staff in the ER and delayed calling EMS.

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

Issue:
Failure to provide notice of report
Summary:
Relevant NOE not issued.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7 Day safety assessment was completed timely. However, the safety decision was incorrect. ACS did not complete a modification safety assessment once the sibling was born and placed in foster care.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Appropriateness of allegation determination
Summary:
The allegations were not properly explored for the BM. The information gathered revealed that she EXCP and that failure to protect the SC contributed to the SC injuries and subsequent death.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Provision of Notice of Indication
Summary:
No NOI was issued for the BM, SF or BF.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:

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

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

The family had no CPS history for more that three years prior to the fatality.

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: 10/22/2014

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:				

The case was open with preventive services (PPRS) from 10/22/14 to 12/29/14. There was no entries documented by the PPRS staff after the SC's admission to the hospital after 11/14/14.

Required Action(s)

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

Preventive Services History

ACS referred the family to Seaman's Society for preventive services (PPRS) and completed a joint home visit (JHV) on 10/6/14. However, the case was rejected after the PPRS learned that the SC was not in the home because the BF did not retuned the SC to the BM.

Once the SC was returned to the BM's home, ACS conducted another JHV with the PPRS on 10/22/14. The PPRS did not see the family after this JHV as the SC was hospitalized on 11/13/14 due to the injuries inflicted by the SF.

Family Assessment Service Planning (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent required FASP approved on time?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☒Yes☐No

Action:	OCFS is recommending that ACS Supervisory Team review with the Specialists the CONNECTIONS' Step-

	by-Step Guide: Training for CPS Workers (rev 3/1/07) page 204, which addresses Safety Assessments, and to review the Safety Assessments submitted for this report.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No