NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-058 **Prepared by: New York City Regional Office**

Issue Date: 12/9/2016

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	

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	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-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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 6 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 06/17/2016
Initial Date OCFS Notified: 06/17/2016

Presenting Information

The 6/17/16 SCR report alleged over the past weekend, the SC was feeling sick for consecutive days, while at home with the other siblings. The mother and parent substitute were aware, but failed to provide medical treatment for the SC, until 6/13/16. The SC was taken to the hospital on 6/13/16, consequently suffered from brain damage. There were no visible signs of trauma. The SC went into a coma while hospitalized and died sometime on 6/14/16. The SC had no preexisting medical concerns that were known, which made the death suspicious.

Executive Summary

This 6-year-old female was declared dead on 6/17/16 at NY Presbyterian Hospital.

The SCR report was requested on same date included the allegations of DOA/Fatality, IG, LS and LMC of the SC as well as IG and LS of the four surviving siblings by the SM and stepfather.

According to the ME, the SM declined an autopsy. NY Presbyterian medical record officially identified the SC's immediate cause of death as brain death due to global hypoxic brain injury with a significant condition of asthma.

As of 11/9/16, NYCRO had not received the death certificate.

According to the record, on 6/6/16 before leaving for work at 8:00 AM, the SM gave the SC the prescribed medication. The SC, the 2-year-old and 8-month-old half-siblings were in the care of the stepfather. At approximately 11:00 AM the stepfather checked the SC who continued to feel ill. The stepfather attempted to administer the prescribed medication however the SC's condition did not change. The step father called the SM and it was determined that the SC required medical attention. The stepfather left the room to dress the two siblings. When he returned to the room he observed the SC on the bed; her skin was a "purple color". It was unclear how long he left the room before returning. The stepfather asked the paternal step uncle to call 911. The 911 operator provided CPR instructions and the stepfather performed CPR on the SC until EMS arrived. EMS arrived on scene at the same time as the SM. EMS continued resuscitation measures. Via ambulance, the SC and SM were first transported to Methodist Hospital and then they were transferred to NY Presbyterian Hospital. The exact time the SC arrived at Methodist Hospital was unclear. The SC remained in the hospital unresponsive to medical treatment. The SC's condition worsened. On 6/13/16 she was placed on a respiratory machine and was maintained on respiratory support until 6/17/16 when she was declared dead. During the SC's hospitalization, the SM remained in the hospital with the SC. The SM and stepfather received caretaking assistance from the MA and a family friend for the surviving siblings.

ACS offered the family bereavement service. The family expressed interest in services and a Family Services Stage (FSS) was opened on 7/14/16 for PPRS.

During the investigation, ACS gathered pertinent information about the circumstances surrounding the SC's death by observing the family's apartment, accounts from the SM, stepfather, relatives, LE, medical, school and hospital staff.

On 8/16/16, ACS unsubstantiated the allegations of DOA/Fatality, IG, LS and LMC of the SC as well as IG and LS of the four siblings by the SM and stepfather based on the accounts of collaterals, review of the timeline and ACS' overall assessment. It was determined the SM and stepfather's protective capabilities had not contributed to the SC's death.

ACS offered the family bereavement services. The family expressed interest in services and the FSS stage was opened on 7/14/16 for PPRS. Later, the family declined PPRS. On 8/11/16, ACS staff confirmed the family was engaged in private community based services. On 9/7/16, ACS successfully assessed the surviving siblings to be safe in the home.

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?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? Yes

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The SCR received the reported allegations on 6/17/16, however, the 24-Hour Safety Assessment was approved on 6/20/16.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)

Action:	ACS must submit a corrective action plan 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:	Timeliness of completion of FASP
Summary:	The FSS stage was opened on 7/14/16. The initial FASP was due on 8/12/16. The FASP was approved on 8/19/16.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must submit a corrective action plan 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:	Predetermination/Assessment of Current Safety and Risk
Summary:	The risk assessment did not explain the stepfather's behavior that suggested a diagnosis of mental illness. The documentation did not reveal the stepfather had a history of such condition.
Legal Reference:	18 NYCRR 432.1(aa)
Action:	ACS must submit a corrective action plan 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 Case Recording/Progress Notes
Summary:	During the review, there were progress notes not entered within the specified 30 day timeframe for timely documentation.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan 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:	Appropriateness of allegation determination
Summary:	ACS did not explain the unsubstantiated decision of the DOA/Fatality of the SC by the SM and step father in the investigative summary narrative.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a corrective action plan 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 inquire from the school staff or the SM as to the reason the SC missed 28 days of

	school. Additionally the ER staff at Methodist Hospital and the responding EMS staff collaterals were not made.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a corrective action plan 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: 06/17/2016 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 06/06/2016
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: 11:31 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 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	6 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)

Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	11 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Year(s)
Deceased Child's Household	Stepfather	Alleged Perpetrator	Male	30 Year(s)

LDSS Response

On 6/17/16, LE interviewed the SM and step parent at the CAC. LE determined there was no criminality associated with SC's death.

ACS conducted a home visit to assess the siblings for safety. The family resided in a one bedroom apartment with two pets. The Specialist observed the SM and stepfather slept in the living room. There was a toddler bed for the SC, the 2, 8 and 11-year-old shared a full size bed and a broken Pack and Play for the 8-month-old sibling. The Specialist assessed there was adequate food in the home, working smoke and carbon monoxide detector and window guards in the home. ACS provided the family with furniture assistance.

According to the SM, the SC was initially treated with medication for a medical condition in December 2015. On 5/29/16, the SC had an episode and the SM took the SC to the ER where she was treated and discharged with medication. Due to the SC's continued illness, the SM took the SC to the Dr. on 5/31/16 and 6/3/16. During both visits, the SC was treated and discharged home. The SM stated there was no change in the SC's prescribed medication.

ACS staff interviewed the two half-siblings who were in school at the time of the incident and neither was aware of the circumstance regarding the SC's death. The 8 and 12-year-old siblings stated the SC was ill on 6/6/16 and was allowed to stay home from school. The 12-year-old denied he had cared for his siblings alone or was left unsupervised in the home or outdoors. The four surviving siblings were observed free of marks or bruises.

During ACS' interview with the SM and paternal step uncle, their statements regarding the events were consistent with the step-parent's account. The paternal step uncle's phone log recorded the 911 call was made at 11:29 AM. The SM and stepfather denied all allegations.

The MA who occasionally babysat for the SC and the siblings denied the children were left alone and unsupervised. All children attended after school and travelled home together where an adult awaited their arrival.

On 6/20/16, the family's Dr. stated all the children's immunizations were current. The SC was seen approximately 6 months prior to the incident and she was prescribed medication. However, the SC was not diagnosed with a medical illness. The SM and stepfather attended all follow up visits. The SM and stepfather were trained to properly administer the medication to the SC. There were no concerns regarding the treatment the SC and siblings received in the care of the SM and stepfather.

On 6/21/16, the hospital staff stated bereavement referral was provided to the family. According to the EMS log, the 911 call was received at 11:31 AM and EMS arrived at 11:36 AM. On 6/22/16, the ME confirmed the SM declined an autopsy.

The Specialist obtained the attendance record for the SC and two siblings. ACS observed the SC had been absent from school more than 28 days during the school year. The reason for the SC's absences was unclear. The siblings received

supportive educational services in school. The school staff had no concerns regarding the children's safety in the home.

On 6/28/16, ACS staff interviewed the BF of the SC, the 8 and 11-year-old siblings. The BF last saw his children around 5/13/16 and was told the SC was sick on 6/6/16. The BF had no knowledge of the SC's medical condition prior to the incident. The BF expressed concern the stepfather was sleeping while the SC was having difficulty breathing. The BF aired concerns to ACS staff regarding the supervision of his three children while in the care of the stepfather. The BF had no concerns to suggest the children were left unattended. The BF denied history or treatment of any medical conditions.

A Child Safety Conference (CSC) was held on 6/29/16. The subjects participated and discussed the safety planning and services for the surviving siblings.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

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
029481 - Deceased Child, Female, 6 Yrs	031123 - Stepfather, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
029481 - Deceased Child, Female, 6 Yrs	031123 - Stepfather, Male, 30 Year(s)	Lack of Supervision	Unsubstantiated
029481 - Deceased Child, Female, 6 Yrs	031123 - Stepfather, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
029481 - Deceased Child, Female, 6 Yrs	031123 - Stepfather, Male, 30 Year(s)	Lack of Medical Care	Unsubstantiated
029481 - Deceased Child, Female, 6 Yrs	029482 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
029481 - Deceased Child, Female, 6 Yrs	029482 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
029481 - Deceased Child, Female, 6 Yrs	029482 - Mother, Female, 30 Year(s)	Lack of Medical Care	Unsubstantiated

029481 - Deceased Child, Female, 6 Yrs	029482 - Mother, Female, 30 Year(s)	Lack of Supervision	Unsubstantiated
029484 - Sibling, Male, 8 Year(s)	031123 - Stepfather, Male, 30 Year(s)	Lack of Supervision	Unsubstantiated
029484 - Sibling, Male, 8 Year(s)	031123 - Stepfather, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
029484 - Sibling, Male, 8 Year(s)	029482 - Mother, Female, 30 Year(s)	Lack of Supervision	Unsubstantiated
029484 - Sibling, Male, 8 Year(s)	029482 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
029485 - Sibling, Male, 11 Year(s)	031123 - Stepfather, Male, 30 Year(s)	Lack of Supervision	Unsubstantiated
029485 - Sibling, Male, 11 Year(s)	029482 - Mother, Female, 30 Year(s)	Lack of Supervision	Unsubstantiated
029485 - Sibling, Male, 11 Year(s)	031123 - Stepfather, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
029485 - Sibling, Male, 11 Year(s)	029482 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
031249 - Sibling, Female, 2 Year(s)	029482 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
031249 - Sibling, Female, 2 Year(s)	031123 - Stepfather, Male, 30 Year(s)	Lack of Supervision	Unsubstantiated
031249 - Sibling, Female, 2 Year(s)	031123 - Stepfather, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
031249 - Sibling, Female, 2 Year(s)	029482 - Mother, Female, 30 Year(s)	Lack of Supervision	Unsubstantiated
031250 - Sibling, Male, 8 Month(s)	029482 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
031250 - Sibling, Male, 8 Month(s)	029482 - Mother, Female, 30 Year(s)	Lack of Supervision	Unsubstantiated
031250 - Sibling, Male, 8 Month(s)	031123 - Stepfather, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
031250 - Sibling, Male, 8 Month(s)	031123 - Stepfather, Male, 30 Year(s)	Lack of Supervision	Unsubstantiated

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
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 incident occurred on 6/6/16 and the SCR report was received on 6/17/16 of the SC's death in the hospital. There was no effort to contact the first responders and ER staff.

Fatality Safety Assessment Activities

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

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

The SCR report was dated 6/17/16. The 24-Hour safety assessment was approved on 6/20/16. The 30-Day safety assessment was approved on 7/19/16.

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes

From: Unknown	**To:** 06/27/2017

Explain:
The SM filed an OOP against the SC's BF for the 8 and 11-year-old siblings and herself. The SC's BF threatened to harm the SM.

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:
The family engaged in bereavement counseling through a referral via the hospital Social Worker. The two older siblings received counseling in the school and arrangements were made for them to attend summer camp as an intervention.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The hospital SW provided the SM with bereavement referral for the surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The hospital SW provided the SM and stepfather with bereavement referral.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	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)
10/17/2013	11032 - Sibling, Male, 9 Years	10932 - Stepfather, Male, 27 Years	Inadequate Guardianship	Indicated	Yes
	11031 - Deceased Child, Female, 3 Years	10932 - Stepfather, Male, 27 Years	Inadequate Guardianship	Indicated	
	11033 - Sibling, Male, 5 Years	10932 - Stepfather, Male, 27 Years	Inadequate Guardianship	Indicated	

Report Summary:
The stepfather was involved in drug activity with the intent to sell drugs with the SC and the 5 and 9-year-old siblings present. The SM had an unknown role.

Determination: Indicated **Date of Determination:** 12/13/2013

Basis for Determination:
ACS substantiated the allegation on the basis that the children witnessed a possible drug sale while in a vehicle with the stepfather. The children witnessed the arrest of the stepfather due to the drugs the police found in the vehicle.

OCFS Review Results:
ACS identified the SM as the primary caretaker in the risk assessment and documented the SM's statement regardless of her presence or not, she was the custodial parent and legally responsible person for all children at the time of the report. The stepfather was not the biological parent and did not care for the children.

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

Issue:
Failure to provide notice of report

Summary:
The NOE was not provided to the BF of the children. Although BF was incarcerated ACS did not explore the BF's exact location.

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

Action:

ACS must submit a corrective action plan 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:
Face-to-Face Interview (Subject/Family)

Summary:
The subject was not the BF of the children. The SM and 9-year-old sibling stated the subject did not reside in the home. ACS did not observe the subject in the home. The SM stated the investigation was an isolated incident and the subject did not routinely provide care of the children. ACS failed to add the SM to the investigation as she was legally responsible for the children.

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

Action:
ACS must submit a corrective action plan 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:
Overall Completeness and Adequacy of Investigation

Summary:
The subject was not biological father of the children. The mother and 9-year-old stated the subject did not reside in the home. ACS did not observe the subject in the home. The mother stated the investigation was an isolated incident and the subject did not routinely provide care of the children. ACS failed to add the mother to the investigation as she was legally responsible for the children.

Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:
ACS must submit a corrective action plan 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.

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

The SM had one indicated report. The 5/18/12 SCR report alleged EdN of the 8-year-old sibling by the SM. ACS substantiated the allegation on 7/12/12 due to the SM having had a stable residence at the time of the report and she had not provided a legitimate reason for the sibling not attending school regularly.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

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

Additional Local District Comments

N/A

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