Child Fatality Report

Report Identification Number: NY-17-053

Prepared by: New York City Regional Office

Issue Date: Nov 28, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 7 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 05/28/2017
Initial Date OCFS Notified: 05/28/2017

Presenting Information

The 5/28/17 SCR report alleged that the 7-year-old SC had asthma. On 5/27/17, the SC was having problems breathing and was seen at Kings County Hospital (KCH). The SC was released on 5/28/17, but continued to have trouble breathing throughout the day. The SM did not call 911 until 8:00 PM. The SC died at about 8:20 PM on 5/28/17. The SM and PS failed to seek medical care in a timely manner.

Executive Summary

The 7-year-old male child (SC) died on 5/28/17. An autopsy was not performed on the SC; however, the ME conducted an external examination. According to the Report of External Examination, the immediate cause of death was listed as Complications of Bardet-Biedl Syndrome and the manner of death as natural. Another significant condition contributing to the death but not resulting in the underlying cause was Chronic Bronchial Asthma.

The allegations of the 5/28/17 report were DOA/Fatality, IG, and LMC of the SC by the SM and PS.

ACS found that the SC had a pre-existing medical condition. The SC was hospitalized from 5/19/17 through 5/24/17 and received medical treatment for wheezing and breathing symptoms. The SC was prescribed medication and his health condition seemed stable after leaving the hospital. The SM said she gave the SC his medication as prescribed. On 5/28/17, the SC awoke around 10:00 AM and he told the SM he did not feel well and did not want to leave the home for the usual outing to the park. SM gave him CHN's Tylenol and stayed indoors with him while she sent the 7-year-old SS to the park with a family friend. SM observed the SC did not have much of an appetite. The SC played a video game while he laid on the living room sofa. During the day, she gave him his prescribed medication. She was unable to recall the time but she believed it was some time after 2:00 PM. About an hour or two after the SM gave the SC a dose of prescribed medication, the SC coughed, wheezed and complained of difficulty breathing. SM gave the SC a prescribed Tx. After completing the first Tx, the SC said he was not feeling any relief. The SM called 911 after the first Tx seemed ineffective. She explained that after the first Tx, the SC's condition was usually improved. EMS arrived while the SC was having a second Tx. The SC was sweating when EMS arrived. He sat on the sofa and began foaming at the mouth.

On 6/1/17, ACS held a conference and discussed concerns about the 7-year-old SS as the SS had a pre-existing medical condition. The recommendations included: court ordered supervision (COS), an appointment with a medical specialist, and attendance in bereavement counseling. On 6/2/17, ACS filed an Article Ten Neglect petition in the Kings County Family Court (KCFC) and requested COS; COS was granted on 6/5/17.

On 7/28/17, ACS Unsub the allegation of DOA/Fatality of the SC by the SM and PS, and Unsub the allegations of IG and LMC by the PS. ACS based the decision on finding of no credible evidence to substantiate. PS was not a person legally responsible; he did not reside in the home. The ME could not determine the SM's actions directly caused the SC's death. The ME ruled the SC's death to be from complications of Bardet-Biedl Syndrome.

ACS Sub the allegations of LMC and IG of the SC by the SM. ACS explained that according to the SM's account of what occurred on 5/28/17, there seemed to be some negligence on her part. She recalled that on 5/28/17, the SC said he was not feeling well at or about 10:00 AM; the SC again told the SM by 2:00 PM he was not getting better. Throughout the day, he showed no signs of improvement. However, from the SM's account she called EMS at about 8:00 PM on 5/28/17. The SC was medically fragile with a host of medical conditions. The SC was discharged from the hospital for symptoms

related to a medical condition days prior to 5/28/17. Considering the SC's medical classification, extensive medical history and having been recently released from the hospital, it appeared that the SM failed to act timely to get the SC medical care on 5/28/17.

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?** 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

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:
NA

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:	Although the 5/29/17 safety assessment was completed timely, the safety assessment was inadequate as there were associated comments that did not support the selected safety factor.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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:	Pre-Determination/Assessment of Current Safety/Risk

Summary:	The 6/29/17 safety assessment was inadequate as a selected safety factor did not have an accurately supportive comment associated with it. The explanation did not match the selected safety factor.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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 documentation reflected that the PS was listed as a subject of the 5/28/17 report and ACS spoke with him; however, he was not interviewed regarding the allegations and the relationship with the family.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	ACS filed an Article Ten Neglect petition due to allegation of LMC of the SS; however, the agency did not include the allegation of LMC of the SS by the SM in the 5/28/17 report.
Legal Reference:	SSL 412(1) and 412(2)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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: 05/28/2017 **Time of Death:** 09:41 PM

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: 08:15 PM
Did EMS 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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	7 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Other Household 1	Other Adult - Parent Substitute	Alleged Perpetrator	Male	25 Year(s)

LDSS Response

The ME reported there was no autopsy. The ME explained the case should not have been under the ME's jurisdiction as the SC died from natural causes. The SC had Bardet-Biedl Syndrome and had complications from Chronic Bronchial Asthma. The SC had a sibling who died at the age of one from the same condition.

On 5/29/17, ACS visited the home and interviewed the SM. The SM said the SC recently received medical care at KCH as he suffered from severe asthma and was ill. She stated that after he was released from KCH, he was in stable health condition. She said that on 5/28/17, the SC told her he did not feel well. She asked him if he had difficulty breathing and he told her he did not. She gave the SC his prescribed medication at about 3:00 PM-4:00 PM, after he ate, but it did not work so she gave him a second one. SM said she always called 911 if his wheezing did not improve after the second Tx. SM called 911 and he began to foam from the mouth as EMS entered the home.

The SM said the SS had a twin who died at one year old due to a medical condition. The SS had a medical condition and was seen by a team of physicians every six months. The SM declined counseling and services. At the time of the visit, the SS was staying with her great maternal aunt (MGA). The SS was seen at the MGA's home and was assessed as safe. Later, the SS said she was at the home when the SC fainted the SM gave him medicine in his machine. ACS clarified that the SC did not go to the park on 5/28/17. The SM said the SC stated he was not feeling well so she gave him CHN Tylenol and stayed home with him. The SS went to the park with a family friend. During a follow up interview, ACS obtained additional information and observed the SC's medication. The SM explained that on 5/28/17, the SC woke around 10:00 AM. After she gave CHN Tylenol he played a video game while lying on the living room sofa. SM gave him his medication some time after 2:00 PM and she checked the SC randomly to monitor his health. SM gave the SC a Tx and then the SC said he was not feeling any relief. Instead of giving him a second Tx and then calling 911, the SM said she called 911 after the first Tx seemed ineffective. SM said the SS was diagnosed with a medical condition, her health status was stable and she was not prescribed medication.

On 5/31/17, ACS contacted NY Presbyterian-Columbia University Hospital (NYPCUH) to obtain information regarding the SC. ACS verified information about the SC's and SS's diagnosed medical condition. It was noted in the SC's record that he was scheduled to visit the medical specialist every six months. SC was reported to have good compliance with the prescribed Tx. The SM had a Hx of good compliance and understood the diagnosis. ACS learned about the family Hx,

specifically pertaining to a sibling dying from a similar diagnosis, and the medical team determined the SS should be monitored every six months. The SS's last appointment was August 2014.

On 6/7/17, ACS submitted a referral for PPRS. On 6/16/17, the medical specialist reported that the SS was examined on 6/16/17. She was assessed to be well and would be scheduled for yearly assessment.

On 7/20/17, a joint home visit (JHV) occurred with ACS and the Edwin Gould Services for Children and Families preventive services program.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041121 - Deceased Child, Male, 7 Yrs	041124 - Other Adult - Parent Substitute, Male, 25 Year(s)	DOA / Fatality	Unsubstantiated
041121 - Deceased Child, Male, 7 Yrs	041124 - Other Adult - Parent Substitute, Male, 25 Year(s)	Lack of Medical Care	Unsubstantiated
041121 - Deceased Child, Male, 7 Yrs	041122 - Mother, Female, 27 Year(s)	Lack of Medical Care	Substantiated
041121 - Deceased Child, Male, 7 Yrs	041124 - Other Adult - Parent Substitute, Male, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
041121 - Deceased Child, Male, 7 Yrs	041122 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
041121 - Deceased Child, Male, 7 Yrs	041122 - Mother, Female, 27 Year(s)	Inadequate Guardianship	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:

The documentation reflected that the PS was listed as a subject of the 5/28/17 report; however, he was not interviewed regarding the allegations and his relationship with the family.

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 or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: An Article Ten Neglect Petition was filed on 6/2/17 and court ordered supervision was granted.				

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/02/2017	There was not a fact finding	There was not a disposition
Respondent:	041122 Mother Female 27 Year(s)	
Comments:	On 6/2/17, ACS filed an Article Ten Neglect Petition in KCFC naming the SM as the respondent based on medical neglect of the SS. The KCFC questioned the ACS decision to parole the SS to the SM. The KCFC appeared to be concerned with the extensive gap in the visits that the SS made to the medical specialist. The KCFC questioned the reasons for not requesting a remand. Family Court Legal Service (FCLS) said that it was a collective perspective of the legal team and CPS team that with services and supervision, the CH would be safe in the home. The KCFC said the CH would be released to the BM for the weekend, but the SM needed to make an appearance with the SC on the next business day or the SS would immediately be remanded to ACS. On 6/5/17, KCFC asked FCLS to present the terms of court ordered supervision. ACS requested that the SM immediately follow-up with obtaining an appointment for the SS with the medical specialist, bereavement counseling for the SS, accepting and participating in PPRS, and follow-up medical appointments for the SS. KCFC granted the COS.	

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 Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☒	☐	☐	☐	☐	☐	☐

Other, specify: Edwin Gould PPRS

Additional information, if necessary:
The family received PPRS to monitor the SS medical needs. SCOFS told ACS that in review of the case it was concluded the SS's condition and care requirement did not meet the prerequisite to be classified as medically fragile.

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 service plan included bereavement counseling for the SS and the selection of a medically specialized PPRS agency to work with the family to address the SS medical needs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
A medically specialized PPRS agency to work with the family since the sibling had a diagnosed medical condition.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
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)
10/23/2014	Sibling, Female, 4 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 4 Years	Mother, Female, 25 Years	Lack of Medical Care	Unfounded	

Report Summary:
The 10/23/14 SCR report alleged that the SM had children with cardiac issues. An infant died with cardiac issues. The SS had cardiac issues as well. It was made clear to the SM that the SS had to be monitored once every year or every two years. On 8/25/14, the SS was treated and was placed on the monitoring machine. The monitoring had been done for 24 hours. The SM was required to return the monitor the next day so as to read, and gauge the SS's medical condition. Since that time until 10/23/14, the SM had not returned the monitor. As a result, there was no way of knowing the SS's medical condition. Telephone calls had been in vain.

Determination: Unfounded **Date of Determination:** 12/11/2014

Basis for Determination:
The social worker (SW) said the SM followed up with all of the SS's medical care, which had to be monitored every 1-2 years and that the SM last brought the SS for her medical care on 8/25/14. During that appointment, SM was provided a medical device. The medical device automatically sent the readings to the clinic the following day. The SW said SM placed the device on the SS for 24 hours as required and the reading was received; the SS was in good health, but SM failed to return the medical device. The SW found no child protective issues, only that SM did not return the medical device. The medical device was returned on 10/24/14 and no other issues were reported.

OCFS Review Results:
The 10/30/14 and 12/10/14 safety assessments were inadequate as the associated comments did not support the selected safety factors. The SW said the SM had not returned a medical device placed on the SS. The SM did not return the device as required. The SW said there were no child protective issues or concerns pertaining to the SS. Later, the SW said the device was returned by a relative. The school staff said the SS received therapeutic services; however, documentation did not reflect these service providers were interviewed. The SM said she had followed up with the SS medical care and returned the device.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 10/30/14 safety assessment was inadequate as the associated comments did not support the selected safety factors that stated the BM was unable and/or unwilling to meet child's needs for food, clothing, shelter, medical, or mental health care and/or control child's behavior.

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

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
The 12/10/14 safety assessment was inadequate as the comments did not support the safety factors that stated child had significant vulnerability, was developmentally delayed, or medically fragile (e.g. on Apnea Monitor) and the SM was unable and/or unwilling to provide adequate care and/or protection of child.

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

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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:
The school staff said the SS received therapeutic services; however, documentation did not reflect the service provider was interviewed.

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

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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 PS was not known to the SCR or ACS.

The SM was known as a subject in five reports dated: 9/3/10, 9/24/13, 3/1/14, 3/17/14, and 3/25/14.

The allegations of the 9/3/10 report were IG of the SC, SS, and now deceased sibling by the parents. On 9/21/10, ACS filed an Article Ten Neglect petition in KCFC naming the SM and BF as the respondents. A remand was granted for all three CHN. The CHN were removed and placed with the Children's Aid Society agency on 10/14/10. On 11/5/10, ACS Sub the allegations.

The allegations of the 9/24/13 report were IG and PD/AM of the SC, SS, and paramour's child (now 10 years old) by the SM and her paramour. On 11/25/13, ACS Unsub the allegations.

The allegations of the 3/1/14 report were IG, L/B/W, and IF/C/S of the SS by the SM and paramour. On 5/2/14, ACS IND the report. The allegations of the 3/17/14 report were IG and IF/C/S of the SC by the SM and paramour. On 5/19/14, ACS IND the report. The allegations of the 3/25/14 report were IG, L/B/W, and S/D/S of the now 7-year-old sibling by the SM. On 6/2/14, ACS IND the report.

Known CPS History Outside of NYS

There was no known CPS History outside NYS.

Preventive Services History

On 2/19/10, a preventive services case was opened in the Family Service Stage (FSS) Advocates Preventive Only (ADVPO), to address DV concerns and parenting needs. SM and BF resided in a family shelter with the SC. The family received casework counseling, batterers counseling, housing services, child care services, parenting training and family support services.

On 3/26/12, the SC and SS were trial discharged to the SM. The adjournment in contemplation of dismissal (ACD) expired on 4/15/13 and the case was referred to PPRS focused on medically fragile needs. The SM cooperated with court ordered supervision. She agreed to the service plan and accepted services. The 9/15/14 FASP reflected that the service plan included: parent aide services, case management, clinical and health related service. A Family Team Conference occurred on 9/8/14 and the SM expressed interest in terminating PPRS. SM said there were no further concerns and she did not believe services were needed. St. Vincent's Services agency assessed the SM had followed up with the service plan goals, including the children's medical needs. The supervisor assessed due to the progress, and completion of the recommendations and service plan goals the case was appropriate for termination of services. The FSS was closed on 10/1/14

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