Child Fatality Report

Report Identification Number: NY-19-046

Prepared by: New York City Regional Office

Issue Date: Nov 04, 2019

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: 13 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 05/04/2019
Initial Date OCFS Notified: 05/06/2019

Presenting Information

The 5/6/19 SCR report alleged the SC (age 13 years) had complained of headaches and body pain for one month prior to her death. The mother was aware of the SC's pain but failed to seek medical attention. On 4/27/19, the SC became ill and was transported to the hospital via ambulance. The report further alleged, due to the mother's failure to take the SC to seek medical attention, the SC sustained strokes, hemorrhages of the brain, and had a high blood glucose. The SC was also diagnosed with leukemia. The SC was in a coma on 4/27/19, and was placed on a ventilator. On 5/4/19, the SC was taken off the ventilator and pronounced dead. The roles of the father and SS were unknown.

Executive Summary

This 13-year-old female SC died on 5/4/19. In July 2019, NYCRO received information from the New York City Office of Chief Medical Examiner (OCME), confirming the case did not fall under the jurisdiction of the OCME. The SC's remains were not brought to the OCME facility. The SC resided with the SM and three SSs, ages 16, 7, and 4 years.

On 5/6/19, the SCR registered a report that included the allegations of DOA/Fatality, IG and LMC of the SC by the SM. At the time of the SC's death, the family had an open investigation that began on 4/12/19. ACS initiated the investigation and found the SC was admitted to the hospital for treatment of terminal illness.

During the investigation, ACS visited the hospital and interviewed medical staff. ACS obtained information regarding the SC’s medical history. ACS learned that prior to her death, the SC had several seizures, strokes and brain hemorrhaging. The SC was transported to the local hospital by EMS on 4/27/19 where she was intubated. The SC was pronounced dead by an attending physician on 5/4/19.

ACS Emergency Children Services assessed the family at the MGM’s home on 5/6/19. ACS interviewed the SM, MGM and three SSs. ACS assessed the SM and the SSs and found the SSs did not have marks/bruises and there was food and working safety devices in the home. ACS learned that the SM followed-up with the sibling's annual physical examinations. ACS did not thoroughly interview the 7 and 16-year-old SSs regarding the events surrounding the death of the SC.

On 7/3/19, ACS unsubstantiated the allegations of LMC, IG, and DOA/Fatality of the SC by the SM. ACS determined that the SC had a rapid and aggressive form of leukemia which caused her death. ACS obtained further information from the medical provider which indicated there were no prior medical concerns or issues.

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

Explain:
Sufficient Information was gathered to make a determination for all the allegations.

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

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

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

Explain:
ACS gathered sufficient information from the medical providers, physician, family members and community resources.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The risk assessment did not include information regarding the subject family's history of unstable housing or no housing.
Legal Reference:	18 NYCRR 432.2(d)
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: 05/04/2019 **Time of Death:** 11:00 AM

Date of fatal incident, if different than date of death: 04/27/2019
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
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	Female	13 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	16 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)

LDSS Response

ACS interviewed the SM on 5/6/19. The SM reported that the SC complained of headaches weeks prior to her death; therefore, she took the SC to a medical specialist who prescribed the SC glasses. The SM reported that the SC was given medication for her headaches. The SM said she did not engage in substance use.

Between May and July 2019, ACS interviewed the SC's physician, paternal aunt (PA), and attending social worker. ACS learned that on 3/27/19, the SC was seen at the medical clinic's urgent care because she complained of headaches.

On 5/6/19, ACS contacted the PA, and learned that the PA advised the SM to take the SC to the physician two weeks prior to 5/6/19; however, the SM refused to take the SC to the hospital. The PA reported that the SC's arm and face were covered in bruises and there was injury to the SC's head.

On 5/6/19, visited the local hospital to obtain further information pertaining to the death of the SC. ACS learned that prior to her death, medical professionals diagnosed the SC with a medical condition. ACS was directed to obtain information from the ME's office.

Subsequently, ACS requested domestic violence and mental health consultations. ACS addressed mental health related trauma associated with the subject family.

On 5/7/19, ACS contacted the attending social worker and learned that the SC had a terminal illness. The social worker reported that the medical staff did not observe any bruises on the SC. ACS met with the medical consultant for the second time and verified, during the period of hospitalization, the SC was pronounced brain dead. ACS obtained a medical consultation with the CAC and learned there was no indication that the SC had bruises on her body or was physically abused.

On 5/13/19, ACS conducted the Initial Child Safety Conference, the subject family did not attend the conference because the SC's burial service was on said date.

Between 6/6/19 and 6/14/19, ACS contacted the ME and learned that the ME did not accept the case as the cause of death was deemed natural as a result of the SC's illness. The SSs were reported to be cared for in the home and continued to receive supportive services through the preventive agency. ACS conducted a follow up Child Safety Conference to discuss services, including bereavement counseling and in-home family therapy.

On 7/3/19, ACS received the medical documentation from the SC's and SSs local medical clinic. Per ACS, the medical personnel had recommended that the SC see a medical specialist and was given information on a headache. Prior to the 2019 investigation, the SC had not had a physical since 2017 and was a no-show at her scheduled medical appointment. It appeared that the SC had headaches for a month.

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: 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
051801 - Deceased Child, Female, 13 Yrs	051805 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
051801 - Deceased Child, Female, 13 Yrs	051805 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
051801 - Deceased Child, Female, 13 Yrs	051805 - Mother, Female, 36 Year(s)	Lack of Medical Care	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	☐	☒	☐	☐
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:

ACS case record did not include information about the first responders who observed the SC and home conditions on 4/27/19.

Fatality Safety Assessment Activities

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

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

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	☒	☐	☐	☐

Explain:
Preventive services, referrals for bereavement and mental health counseling along with rental assistance was offered and accepted by the subject family.

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:
The SSs remained in the home. Although there was no immediate or impending danger of harm, the family remained in preventive services for monthly monitoring and services.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
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 received PPRS. ACS and GSS offered burial assistance; however, it was unknown if the parents accepted. The SSs were examined at the local medical clinic and deemed well children.

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:
ACS and Good Shepard Services (GSS) referred the SSs for immediate bereavement counseling and in-home therapy.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS and GSS referred the SM for immediate bereavement counseling and in home therapy.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/12/2019	Deceased Child, Female, 13 Years	Mother, Female, 36 Years	Educational Neglect	Substantiated	No
	Deceased Child, Female, 13 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 13 Years	Mother, Female, 36 Years	Internal Injuries	Unsubstantiated	
	Deceased Child, Female, 13 Years	Mother, Female, 36 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Female, 13 Years	Mother, Female, 36 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The 4/12/19 report alleged the SC (age 13) had a history of poor attendance in school. Last school year the SC was absent 71 days. The 2019 school year the SC was absent 71 days, and the last 30 days had been consecutive. There were attempts to address the SC's attendance with the SM through phone calls, letters and home visits. The SM did not respond and as a result, the SC was academically failing.

Report Determination: Indicated | **Date of Determination:** 06/11/2019

Basis for Determination:
ACS found credible evidence to substantiate the allegations of EN of the SC by the SM based on the SC not attending school because she was bullied. The SC refused to continue attending school and requested a transfer and the SM did not intervene.

ACS visited the family and obtained information from various collateral contacts and did not find credible evidence to substantiate the allegations of II, L/B/W and LMC because there was no evidence of injury to the SC. The SC was hospitalized for having a sudden terminal illness.

OCFS Review Results:
Based on the information obtained in the course of the investigation, ACS' decision to substantiate the allegation of EN of the report was appropriate.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/31/2018	Deceased Child, Female, 11 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 16 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 7/31/19 report alleged on an ongoing basis, the SM screamed, yelled and hit the children, names unknown (age 15, 11, 5 and 3) in an out of control manner. The SM also yanked the three-year old's arm with force.

Report Determination: Unfounded | **Date of Determination:** 10/01/2018

Basis for Determination:
During the 7/31/18 investigation, ACS visited the family and obtained information from various collateral contacts. ACS did not find credible evidence to substantiate the allegations of IG of the SC and SSs by the SM. According to ACS, the children were never observed with any marks or bruises. The SM was never observed out of control or aggressive with the children.

OCFS Review Results:
Based on the information obtained in the course of the investigation, ACS' decision to un-substantiate the allegation of the report appeared premature. ACS did not further explore possible abuse/maltreatment of the 3-yo male SS, who had sustained scratches on his shoulder while in the care of the SM. The 3-yo SS was allegedly burned by the SC. ACS documented that the SC was observed with scratches on his right shoulder, 2 cm and 1 cm in length. ACS did not probe further to determine whether the SM took the male SS to the physician. Some of the progress notes were not written contemporaneously.

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

Issue:
Timely/Adequate 30-Day Safety Assessment

Summary:
The progress notes during the 7/31/18 investigation were not written contemporaneously. ACS entered a note on 10/1/2018 with an event date of 8/6/2018.

Legal Reference:
CPS Program Manual, Chapter 6, K-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.

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
ACS did not further explore the 3-yo male SS, scratches on his shoulder with the SM. The 3-yo male SS reported that he was burned by his sibling. ACS documented that the SC was observed with scratches on his right shoulder 2 cm and 1 cm in length. ACS did not probe further and inquire whether the SM took the male SS to the physician after he was burned.

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

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/27/2017	Deceased Child, Female, 11 Years	Mother, Female, 34 Years	Educational Neglect	Substantiated	Yes
	Sibling, Male, 5 Years	Mother, Female, 34 Years	Educational Neglect	Substantiated	
	Sibling, Male, 5 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Female, 15 Years	Mother, Female, 34 Years	Educational Neglect	Substantiated
Deceased Child, Female, 11 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
The 9/27/17 report alleged the SS age (5) and SC age (12) did not attend school for the 2017 school year. The SM was aware, and she did not address the the children's school attendance concerns.

Report Determination: Indicated | **Date of Determination:** 11/22/2017

Basis for Determination:
During the 9/27/17 investigation, ACS visited the family and obtained information from various collateral contacts. ACS found credible evidence to substantiate the allegations of IG, and Edn. The SM admitted she did not take the children to school. She said she was in the process of transferring from a shelter in Brooklyn to a shelter in the Bronx. The SM reported that due to her health condition, she experienced difficulty with making appointments as well as travelling with the children.

OCFS Review Results:
Based on the information obtained in the course of the investigation, ACS' decision to substantiate the allegations of the report was appropriate. ACS did not document progress notes contemporaneously and did not assess the children within 24 hours of receiving the 9/27/17 report.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
ACS did not document progress notes contemporaneously. ACS entered a progress note on 11/22/17 with an event date of 10/20/2017.

Legal Reference:
18 NYCRR 428.5

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:
Timely/Adequate 24 Hour Assessment

Summary:
ACS did not assess the children through face-to-face contact within 24 hours of receiving the report. The report was registered and received by ACS on 9/27/17 and ACS made the initial face-to-face contact with the children on 10/2/17.

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.

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

The SM was known to the SCR as a non-confirmed subject in a report dated 11/19/10. The allegations of the 11/19/10 report were IG, and PD/AM of the SC and older SS by the SM. The report was unfounded.

Known CPS History Outside of NYS

According to ACS documentation, following the closure of the 11/19/10 investigation, a report was registered with the Department of Social Services in Pennsylvania (LDSS PA). ACS learned that LDSS in PA had difficulty servicing the family; therefore, the case was closed and unfounded.

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: 11/22/2017

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 11/22/2017

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☐	☒	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☐	☐	☐	☒
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
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?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☐	☒	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

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

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: Lower East Side Union and Good Shepard Services (GSS) provided preventive services to the family.				

Required Action(s)

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The service provider (Lower East Side Family Union) did not comply with family face to face contacts. In the month of June the children were assessed one time during a home visit on 6/7/18.
Legal Reference:	432.1 (o)
Action:	Lower East Side Family Union 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. Lower East Side Family Union must meet with the staff involved with this case and submit a response to the issues documented.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The service provider (GSS) saw the family once for the month of December (12/11/18 and February (2/26/19).
Legal Reference:	432.1 (o)
Action:	GSS 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. GSS must meet with the staff involved with this case and submit a response to the issues documented.

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	GSS notes were not written contemporaneously. A progress note entered on 4/25/19 had an event date of 3/20/19. A progress note entered on 6/24/19 had an event date of 5/13/19.
Legal Reference:	18 NYCRR 428.5
Action:	GSS 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. GSS must meet with the staff involved with this case and submit a response to the issues documented.
Issue:	Provide preventive services according to the needs of the child and the child's family
Summary:	Per ACS, the subject family was in need of mental health counseling. The notes indicated the subject family was not engaged in mental health counseling in home or within the community prior to or during the fatality.
Legal Reference:	18 NYCRR 423.4(a); SSL 424 (13)
Action:	GSS 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. GSS must meet with the staff involved with this case and submit a response to the issues documented.

Preventive Services History

The family received preventive services beginning 11/20/17. Lower East Side Union, and GSS had case planning responsibility, and noted no issues regarding the SC and the SS's health. GSS visited the family at the home on 4/23/19. There was no documentation that the SC had been ill or experienced headaches at that time. GSS Home Health programs scheduled medical examinations for the SC and SSs on 4/29/19 and 4/30/19. The physician's notes from an urgent care visit in March 2019 indicated the SC had headaches for approximately a year and it was unknown if the SM was made aware of the SC's medical complaints. There was no documentation by the agency that the SM had a medical illness that was hereditary and could be genetically passed to her children; therefore, requiring annual examinations to ensure the children remained healthy. The SM and SC requested mental health treatment but the SM did not follow-up with the referrals the preventive agency submitted.

The agency made consistent biweekly home visits between 2017-2019. Some of the progress notes were not contemporaneous and were documented 30 days after the events occurred in 2019. The CP last reassessment FASP was due on 12/10/18 and submitted 12/20/18 (10 days overdue).

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

There are no additional Local district comments.

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