Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-20-004

Prepared by: New York City Regional Office

Issue Date: Jul 11, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 01/10/2020
Initial Date OCFS Notified: 01/10/2020

Presenting Information

The SCR registered two reports stating the father placed the two-month-old children down for a nap in their respective cribs at an unknown time. The reports stated the father awoke at about 3:00 P.M.; and found the children pale and unresponsive. At about 3:10 P.M. The father alerted the shelter staff who administered CPR and called 911. The father provided conflicting information and had no plausible explanation for the deaths of the children; therefore, the deaths of the children were deemed suspicious as they had no preexisting condition.

Executive Summary

The fraternal twins were a month old at the time of their deaths. As of the writing of this report, the ME had not issued an autopsy report or provided a preliminary cause and manner of death.

At the time of the SC's death, they resided at a family shelter with their father. The family was under court ordered supervision (COS) with ACS' Family Services Unit (FSU), and the mother had been excluded from the home by the Queens County Family Court (QCFC).

On 10/28/19, ACS had filed an Article Ten Neglect Petition on behalf of the SC naming the mother as the respondent. ACS filed for a remand of the SC based on the mother's extensive CPS history in NC and VA involving her six older children. The judge released the SC to their father with court ordered supervision (COS) and a full stay away OP was issued against the mother on behalf of the SC. Based on the mother's CPS history, ACS's Family Court Legal Services (FCLS) concluded the mother should not return to the family shelter until she completed a psychiatric evaluation. ACS was not in agreement to the release of the SC to the father because he had no plan to care for the SC. Based on the father's history of DV and drug use, ACS had concerns about his ability to care for the SC and services were planned for him that would include anger management, random drug screening and parenting skills. On 11/7/19, the father was introduced to ACS' Family Preservation Program (FPP). ACS informed the QCFC that there were no concerns about the care the father was providing to the SC.

On 1/10/20, the SCR registered a report regarding the deaths of the SC with the allegations of DOA/FATL and IG against the father.

ACS' investigation revealed that on 1/10/20, the father found the SC in their cribs unresponsive and sought assistance from the shelter staff who called 911. EMS arrived at the shelter and transported the SC to the Elmhurst Hospital. The male child was pronounced dead at 4:02 P.M., and the female at 4:08 P.M.

ACS initiated the investigation timely and made all relevant collateral contacts, but neither the NYPD nor the ME was able to provide any information regarding the SC's deaths.

ACS attempted to assess the family's shelter unit, but it was initially deemed a crime scene. Later, ACS was not allowed to enter the unit as the parents were no longer allowed to remain at the shelter because they had no other children. However, according to the NYPD, the unit was in complete disarray, there were bugs, opened formula, a lot of baby bottles, a strong smell of marijuana; and the temperature in the room was extremely hot. The FDNY's lieutenant responded to the shelter due to the unusual occurrence to test for carbon monoxide, but none was found.

The SC's pediatrician had no concerns about the SC's medical condition or the parents' actions. The pediatrician indicated that none of the SC's conditions could have contributed to the SC's death.

A review of the case record confirmed that ACS' FSU unit made regular visits to the unit to supervise the mother's court ordered visitations. The visits with the mother appeared to be going well and the documentation reflect she was very active with cleaning, doing the family's laundry, and very attentive to the SC's needs. However, the case documentation did not provide an ongoing assessment of the father's ability to care for the SC. The FSS documentation did not reflect a clear and concise monitoring of the court mandated services for either parent.

On 5/12/20, the NYPD closed their investigation pending the results of the ME's report. The NYPD explained that although the SC's simultaneous deaths were suspicious there was no evidence to arrest the father as there was no indication the father caused or contributed to the SC's death.

As of the writing of this report, ACS had not made a determination regarding this investigation.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Unable to Determine

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Unable to Determine

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

Explain:
There are no surviving children in the parents' care.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Child Fatality Report

Date of Death: 01/10/2020 **Time of Death:** 04:08 PM

Time of fatal incident, if different than time of death: 04:02 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 03:10 PM
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? No - but needed
At time of incident supervisor was:

- ☒ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 2
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	31 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Month(s)

LDSS Response

Upon receipt of the reports, ACS contacted the NYPD who reported when they arrived at the scene, the father appeared to be in distress. He did not appear to be under the influence of any substance. The unit was in complete disarray, had a strong smell of marijuana, and there were butts found in an ash tray. The detective found the temperature in the unit was around 85 degrees Fahrenheit, which felt uncomfortably hot. The detective indicated the footage of the shelter's security cameras, showed the father arrived at the shelter with the SC on 1/9/20 at 8:30 P.M. The father was not seen again until 1/10/20 at 3:00 P.M., holding the SC. The father reported on 1/10/20 he woke up around noon and fed the SC and then placed them back in their pack-and plays for a nap at about 1:30 P.M. The father said he placed the babies on their side because of their medical condition, wrapped them in a blanket, and propped them up against the boppy pillow. The father

said the mother called at about 3:00 P.M. and he noticed the SC were not breathing so he told the mother to call 911. The detective stated the mother was also interviewed and they compared the father's timeline and the parents' accounts using the parents' phones and the shelter's video footage. This revealed the father's time line and account of events were consistent.

The medical staff from the hospital reported the SC had no pulse or heart rate; they were cold, limp and had a body temperature of 92-degree Fahrenheit when they arrived at the ER. They had no marks, bruises, broken bones, or signs of trauma. There were no visible signs of suffocation, and their throats were clear.
ACS interviewed various shelter staff who reported that on 1/10/20, the father poked his head from unit door screaming that he needed help. Shelter staff called 911 at 3:09 P.M. and assisted with CPR until EMS arrived. No one saw the condition of the SC at the time of discovery.

The family's CM reported they came to the shelter in October 2019, prior to the SC's birth. The CM reported she had never observed the father to be under the influence; however, when he first arrived, they confiscated alcohol and marijuana from him. The CM reported the father was non-compliant as he was not cooperative with the room checks or actively planning to obtain permanent housing, and did not keep his appointments. The administrative staff reported there were no problems with the heating system in the building on the day of the incident.

The father's account of events and timeline was consistent with the information he provided to the NYPD. ACS explored with the father about his use of marijuana, and he explained that on 1/9/20, between 10:00PM and 11:00PM he smoked in the bathroom. The father reported the SC kept him up from midnight until 12:00 P.M. PM on 1/10/20. The father reported the female SC cried most of the night and needed to be held a lot. The father said after the SC's last feeding, he laid them in their pack-and plays on their boppy pillows facing him. The father said he received safe sleep information and from the ACS worker who told him that he needed to supervise the SC when he used the boppy pillow; however, the father estimated he dosed off for about 40 minutes. The father said the mother called him at about 3:00PM and while talking to her, he checked the SC, and they were both slouched down with their faces in their pillows; neither child was breathing. The father said he initiated CPR, opened the door to the unit, and called for help. The father said that he called 911 and asked the mother to call 911.

The father reported that on 1/8/20 the mother arrived with the ACS supervisor for a visit. The supervisor commented that unit was cold, so the mother turned up the thermostat, and closed the bathroom door and window. The father said he never touched the thermostat. ACS interviewed the mother who confirmed the father's account and timeline.

ACS has not yet made a determination.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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: There was no documentation of an MDT response; however, the investigation adhered to previously approved protocols for joint investigations.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054474 - Deceased Child, Female, 2 Mons	054476 - Father, Male, 31 Year(s)	DOA / Fatality	Pending
054474 - Deceased Child, Female, 2 Mons	054476 - Father, Male, 31 Year(s)	Inadequate Guardianship	Pending
054478 - Sibling, Male, 2 Mons	054476 - Father, Male, 31 Year(s)	DOA / Fatality	Pending
054478 - Sibling, Male, 2 Mons	054476 - Father, Male, 31 Year(s)	Inadequate Guardianship	Pending

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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

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:
After the SC's deaths, the family had no contact with ACS, the mother discontinued services, and the parents were no longer eligible to reside at the shelter.

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? N/A
Explain:
There were no surviving siblings or children in the home.

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? Yes
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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)
10/13/2019	Deceased Child, Female, 7 Days	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated	Yes
	Other Child - Deceased male sibling, Male, 7 Days	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The SCR registered a report on 10/13/19 pertaining to the birth of the twins, as the mother had a child welfare history outside NYS where she lost the custody of her six older children for unknown reasons. The twins were born prematurely and delivered by cesarean section. The report alleged the father had to be removed from the labor and delivery ward by the hospital police due to his refusal to follow procedures. The twins toxicology results were negative.

Report Determination: Indicated **Date of Determination:** 11/27/2019

Basis for Determination:
ACS substantiated the allegation of IG of the twins by the mother based on her history with her older children.

OCFS Review Results:
ACS' overall investigation was not thorough as safety assessments were not properly completed in practice or in the instruments. ACS based the safety concerns solely on the mother's out-of-state CPS history regarding her other children and made no in-depth assessment of the father's ability to care for the children despite his current drug use, his history of DV, and criminal offenses. This was evident in the documentation of the CSCs and progress notes regarding court events.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:

ACS selected a Safety decision and documented a safety plan that did not reflect the family circumstances. The instrument was approved and there was no supervisory review to reflect a safety modification was considered.

Legal Reference:

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

Action:

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

ACS' completion and responses of the questions contained in the RAP reflected ongoing contradictions to the information obtained and documented throughout the investigation.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

Issue:

Adequacy of Progress Notes

Summary:

The notes throughout the investigation were not clear and concise.

Legal Reference:

18 NYCRR 428.5

Action:

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

ACS not asked relevant question when contacting the source or collateral. Also, the information obtained did not from collaterals did not reflect timely and/or adequate follow up.

Legal Reference:

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

Action:

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

Issue:

Adequacy of services following the fatality

Summary:

The documentation of services following the fatality did not reflect that court mandated services were monitored closely, particularly for the father who was ordered to submit to random drug screening, and was the primary caretaker of the SC.

Legal Reference:

18 NYCRR 432.2(b)(4);428.6

Action:

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

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The documentation of all three safety assessments did not provide any safety factors that were current to the safety of the SC, neither was there a comprehensive service plan. However, all were approved.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

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

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

The investigation was inadequate in all areas as it did not focus on the current circumstances of the case. The guidance provided to the CPSS was not clear and concise and the investigative actions were not reviewed properly. This was evident by the approval of assessments that were not completed properly.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

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

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

The parents had no CPS investigation that occurred more than three years before the fatality that involved 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.

Known CPS History Outside of NYS

The mother was known to child welfare in NC and VA pertaining to her six older children ranging from ages 2 through 14 years old. ACS contacted both states and learned the mother was a maltreated child and was known to children's services and Family Court in NC and VA. The history indicated she no longer had custody of any of her six children. At the time of the current investigation, the 14-year-old child was living in group home in NC, the 13 and 10 year old children were in their father's custody; the six-year-old and five-year-old were adopted, and the two-year-old was in VA in the custody of a MGC.

According to the other states, the mother had untreated MH issues and failed to plan for her children.

Services Open at the Time of the Fatality

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: 11/17/2019

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?	☐	☐	☒	☐

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to 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:**
10/28/2019	There was not a fact finding	There was not a disposition
Respondent:	052807 Mother Female 30 Year(s)	
Comments:		

Have any Orders of Protection been issued? Yes	
From: 10/28/2019	**To:** Unknown
Explain: A fully stay away OOP was issued against the mother and as a result she was removed from the home.	

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