Child Fatality Report

Report Identification Number: NY-21-025

Prepared by: New York City Regional Office

Issue Date: Sep 08, 2021

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: 1 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 03/10/2021
Initial Date OCFS Notified: 03/10/2021

Presenting Information

The SCR registered three reports regarding the death of this one-month-old male child. The first report alleged on 03/08/21, at approximately 2:00AM, the parents fed and burped the child, and then went to sleep. At approximately 5:30AM, the parents awoke to find the one-month-old child unconscious. The parents called 911 for help. The parents began performing cardiopulmonary resuscitation on the child. Emergency Medical Services (EMS) responded to the house, took over, and intubated the child who was transported to the hospital via EMS. Initially, it was determined that the child suffered from a cardiac arrest. At the hospital, the child was put on a ventilator while several tests were performed. The results from the testing determined the child suffered from a right and left brain bleed. On 03/10/2021, at approximately 4:13 P.M., the child was pronounced dead. The parents had no explanation for the injuries and death of this otherwise healthy child who had no known preexisting medical conditions.

A second report alleged on 3/8/2021, the subject child was in the care of the mother, the father, and the grandmother. The child was last seen alive when at least one of the three adults checked on him at 2:00AM. Later on 3/8/2021 at 5:00AM, the child was found unconscious by one of the three adults. The child was transported by EMS to a hospital at that time, and remained unconscious at the hospital from 3/8/2021 until 3/10/2021 at 4:13PM, when he was pronounced dead. The report alleged the child was an otherwise healthy child and the parents, and grandmother failed to provide explanation for what caused the child to become unconscious or for his death.

The third report alleged on 3/8/21, the child stopped breathing and sustained a brain bleed and retinal hemorrhaging. There was no explanation for how the child sustained the injuries, making them suspicious. The child was in the care of the mother and the father at the time the injuries were sustained. Therefore, they were made the alleged subjects. The grandmother had an unknown role.

Executive Summary

This fatality report concerns the death of a one-month-old male subject child that occurred on 3/10/21. Three reports were made to the SCR on that same date with allegations of Internal Injuries, Inadequate Guardianship and DOA/Fatality against the child's parents. The New York City Administration for Children's Services (ACS) received the report and investigated the child's death. The cause of death was listed as abusive head and neck trauma and the manner of death as homicide.

At the time of death, the child resided with his parents and paternal great grandmother. There were no surviving siblings or children in the home.

ACS's investigation revealed during the weekend of 3/6/21, the family went out together and upon their return they noticed the child's temperature was elevated; when the mother took the temperature, it was 101 degrees Fahrenheit. The parents did not seek medical attention for the child; instead, they opted to administer over-the-counter medication and the child went to sleep. On the morning of 3/8/21 the child began crying. The parents said the father fed the child, swaddled him and then left the child to go to the kitchen for water. Upon the father's return the child was not breathing and appeared to be "like a noodle". The parents called for EMS and the child was transported to the hospital in cardiac arrest. The child remained on life support until 3/10/21 when he died.

Medical personnel indicated the child was resuscitated in the emergency room; however, there was no brain activity; X-

rays and CT scan showed severe brain injury consistent with shaken baby syndrome. There were no other injuries, bruises, or fractures, noted on the child's body.

From the time the investigation began to the time of its closure, ACS interviewed family members and collateral sources. As of the issuance of this report, law enforcement had not made any arrests regarding the death of the child; however, their investigation is ongoing.

ACS documented there was credible evidence to substantiate the allegations of DOA/Fatality, Internal Injuries and Inadequate Guardianship against the parents and paternal great grandmother based on information gathered and collateral account obtained during the course of the investigation. ACS documented the three adults were the caretakers and they resided at the case address with the child from birth until 3/8/21 when the child was admitted to hospital with injuries and subsequently died. However, the parents and PGGM had no explanation for the child's injuries and death. To support the decision, ACS also documented medical information reflected the child had non-accidental injuries and trauma due to suspected shaken baby syndrome.

The parents were provided referrals for bereavement counseling due to the demise of the child. Additionally, both parents were also provided referral for substance abuse and clinical health counseling due to parental history and ongoing marijuana use.

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?** N/A

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 determination for all allegations.

Was the decision to close the case appropriate? Unknown

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:
The level of casework activity, which includes contact with the family and others from the receipt of the report was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	Case documentation did not reflect contact with EMS to establish a time frame for events or to obtain an assessment of the family and the child's condition at the time EMS staff were in the home.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/10/2021 **Time of Death:** 04:13 PM

Date of fatal incident, if different than date of death: 03/08/2021

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 05:32 AM
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
How long before incident was the child last seen by caretaker? 3 Hours
At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **Unknown**

Total number of deaths at incident event:
Children ages 0-18: 01
Adults: 00

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age

Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	76 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)

LDSS Response

On 3/10/21, the Specialist contacted the hospital staff and learned the child was removed from the ventilator and pronounced dead at 4:13PM on 3/10/21. The Specialist learned that the father said he found the child unresponsive at about 5:00AM. When EMS arrived at the case address, the child was triaged, intubated at 6:15AM, and then placed on a ventilator upon arrival at the hospital. The child's body temperature was 89.6 degrees Fahrenheit at the time. The medical notes reflected the parents reported the child had a fever of 101.2 degrees for two days and became unresponsive after being fed. The child did not have any rashes or bruising.

On the same date, the Specialist interviewed the detectives investigating the possible criminal aspects of the child's death. At the time of contact the detectives reported they were awaiting the ME's preliminary report of the cause of death for the child. According to the detectives, the child had severe brain and retinal bleeding. The detectives added the parents were interviewed twice and their accounts remained consistent.

Medical collateral revealed the child arrived at the hospital in the morning of 3/8/2021, between 5:00AM and 6:30AM via ambulance. The parents reported the father found the child not breathing at home around 5:00AM. EMS was called to the home; lifesaving techniques were performed, and the child was resuscitated at the hospital. The physician stated according to the medical record, the parents told medical staff during the two days prior to being hospitalized, the child had an intermittent fever, and on 3/8/21 at about 5:00AM when the father went to feed the child, the child was not breathing. The parents initiated CPR until the ambulance was called. The physician stated there was no fractures or other injuries; however, within twelve hours of arriving at the hospital, the child was observed to have bleeding in the brain. A CT scan of the head confirmed there was significant bleeding. The bleeding was indicative of an injury that was not recent. The physician stated the parents maintained their account of the incident. The physician indicated other medical specialists examined the child and found retinal hemorrhage. The child had non-accidental trauma, indicative of abuse, possibly shaken baby syndrome. The parents did not provide any explanation to the hospital staff regarding what could have caused the child to sustain bleeding to his brain.

On 3/11/21 ACS contacted the Medical Examiner who stated the autopsy was not yet complete as additional microscopic tests were needed for a definitive cause and manner of death. The Medical Examiner confirmed the hemorrhaging.

Also, on 3/11/21, contact was made with the parents. The father reported he observed the child not breathing. The father said on 3/8/21 he last fed the child at 3:30AM and the child remained awake until 4:45AM. The father said he swaddled the child and left his feet out because that is how he was comfortable leaving the child. He said he placed the child on his back in the Pack-n-Play and left the room to get water. The father said there were no toys or pillows in the child's sleeping area. The father said upon his return, he noticed the child was not breathing or moving. He said he tapped the child, placed his hand on the child's chest, and noted the child's chest was not moving. He then placed his finger in the child's mouth and there was no response. The father said he woke up the mother and he began to perform CPR as the mother was scared and crying. The father stated that he called 911 at 5:30AM. The case documentation did not reflect contact with EMS to confirm the timeline of events from the time of the call to the time the child arrived at the hospital. The mother's account was consistent with the information provided by the father.

The father further explained that on 3/5/21, the child spiked a fever of 100 degrees Fahrenheit and was given 2.5ml of infant Tylenol. The father said he read the dosage on the box and administered the amount to the child. The father said the

child remained fussy during the entire weekend and they continued to administer Tylenol and gave the child Pedialyte. The family did not seek medical attention for the child during the weekend as they were scheduled to see the pediatrician on 3/10/21. The family added they were scared the child would contract the COVID-19 virus, so they decided to remain at home. ACS assessed the parents' protective capacity as low as the parents failed to seek medical assistance for a one-month-old child whose fever was at or over 100 degrees and who had been sick for more than two days.

The Specialist spoke with the Child Abuse Specialist at the hospital and learned the extent of the child's injuries. The Child Abuse Specialist confirmed the child had extensive subdural bleeding on both sides of the brain along with an edema or swelling of the brain.

On 3/12/21, the Specialist conducted a home visit to the case address and documented that despite the clutter evident in the home, there were supplies for the parents and subject child. The Specialist noted the infant Tylenol, vitamins and Pedialyte the parents said they administered to the child during the time the child was not well.

At the time of the visit, the Specialist interviewed a family friend who described the father as "gentle and delicate" towards the child. The friend said the father did not have any clinical health concerns and did not use drugs. This information was in direct contradiction of information obtained from prior history, contact with clinical professionals. The friend further stated that the father was responsible for caring for the child during the nights while to mother took care of the child during the days. The friend also stated she was told the child was not well and had kept in touch with the family during the weekend prior to the child's death. Her contacts were done via video. The friend said the paternal great grandmother had limited contact with the child.

The Specialist contacted neighbors who described the father as "immature" and "impulsive." The neighbor described the father's past aggression and ongoing drug use. The neighbor said there was drug use in the home a week before the child died. The neighbor said she did not know the child's mother.

The Specialist also interviewed the paternal great grandmother who reported she was in the home at the time the child was taken to the hospital. The paternal great grandmother said the child was not sick but was crying a lot. She stated she told the parents to place the child on his stomach, put the blanket over his back and rub his back. The paternal great grandmother said she did not provide care for the child.

On 3/18/21, ACS contacted the maternal grandmother who reported she had last seen the child on 3/4/21 and at that time the child was "puking a lot." The maternal grandmother said she told the mother to take the child to the doctor. She said she did not follow up with the mother about the child.

On 3/22/21, The Specialist contacted the detectives. No new information was obtained. The detectives reported no arrests would be made until information from the final autopsy report was received and reviewed.

The case documentation reflected biweekly contact with the Medical Examiner regarding the autopsy. The Medical Examiner indicated the autopsy could take up to six months to be finalized.

On 4/8/21, ACS contacted the parents and maternal grandmother, and learned the child's body had been cremated. The parents refused all referrals for services. The parents reported they were fully employed and did not need the services.

On 5/10/21, ACS substantiated the allegations of the report. The case remained open until 9/1/21 as ACS continued to make attempts to engage the parents around services to assist them. The parents again refused all assistance and the case was closed.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

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
057046 - Deceased Child, Male, 1 Mons	057047 - Mother, Female, 21 Year(s)	DOA / Fatality	Substantiated
057046 - Deceased Child, Male, 1 Mons	057047 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
057046 - Deceased Child, Male, 1 Mons	057047 - Mother, Female, 21 Year(s)	Internal Injuries	Substantiated
057046 - Deceased Child, Male, 1 Mons	057048 - Father, Male, 25 Year(s)	DOA / Fatality	Substantiated
057046 - Deceased Child, Male, 1 Mons	057048 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
057046 - Deceased Child, Male, 1 Mons	057048 - Father, Male, 25 Year(s)	Internal Injuries	Substantiated
057046 - Deceased Child, Male, 1 Mons	057050 - Grandparent, Female, 76 Year(s)	DOA / Fatality	Substantiated
057046 - Deceased Child, Male, 1 Mons	057050 - Grandparent, Female, 76 Year(s)	Inadequate Guardianship	Substantiated
057046 - Deceased Child, Male, 1 Mons	057050 - Grandparent, Female, 76 Year(s)	Internal Injuries	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐

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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
While there was contact with law enforcement the case documentation did not reflect contact with EMS.

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.

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	☐	☐	☐	☐	☐	☒	☐

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 are no surviving sibling or children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Parents were referred for bereavement and substance abuse counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
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)	Status/Outcome	Compliance Issue(s)

01/22/2021	Deceased Child, Male, 30 Minutes	Mother, Female, 21 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Male, 30 Minutes	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Deceased Child, Male, 30 Minutes	Father, Male, 25 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 30 Minutes	Father, Male, 25 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
The mother gave birth to a male child and the mother's toxicology was positive for marijuana at the time of delivery. The infant's toxicology was pending. The father's role was unknown.

OCFS Review Results:
The case met the district's FAR eligibility criteria and an adequate assessment of safety was completed within 24 hours. Staff saw the child and the parents. The family was informed about FAR and the traditional investigation tracks for a CPS response. The family agreed to accept FAR. Staff documented the presence of a crib and discussed safe sleeping position for infants, with the parents who acknowledged they were aware of safe sleep practices. The parents demonstrated how they fed the infant and how they placed the infant in his crib to sleep.

The decision on the 7-Day Safety Assessment was appropriate, as there was no evidence of immediate or impending danger of harm at the time the assessment was completed.

All adults in the home were interviewed. Risk issues including the possibility of having the paternal grandmother care for the child were discussed. The parents indicated they would never ask the paternal grandmother to watch the child at anytime as she was an alcoholic who could sometimes become inebriated to the point of losing consciousness and requiring hospitalization.

Case documentation further reflected the adults in the home participated in the completion of the Family Led Assessment Guide. However, there was no in-depth discussion of the parents' prior history and how this might affect the parent's ability to properly care for their newborn. The family was not fully engaged, and referrals for mental health and substance abuse services were not made.

It was noted the case was transferred from one FAR unit to another and there was no warm hand-off in this process. While it is not a requirement, such a hand-off could ensure the level of continuity and engagement of the family in services. The FAR case was ongoing at the time the child was injured. As a result, a new report was registered and the FAR case was eventually closed.

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

Issue:
FAR-Failure to Offer and/or Provide Needed Services

Summary:
ACS was aware of the parents drug use, the father's clinical health issues and history of violence, and documented the parents were unwilling or unable to understand the impact of their drug use on their ability to properly care for the child; however, concrete services were not offered to the family at the time of the FAR engagement/involvement.

Legal Reference:
18 NYCRR 432.13 (e)(2) (vi) & (vii)

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.

[redacted]

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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