NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-017 **Prepared by: New York City Regional Office**

Issue Date: 8/24/2015

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
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	MN-Medical Neglect	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 02/22/2015
Initial Date OCFS Notified: 02/22/2015

Presenting Information

On 2/22/15, the mother found the two-month-old male infant unresponsive and not breathing in his crib. Emergency Medical Services was contacted but their attempts to resuscitate the infant were unsuccessful. The infant was transported to the hospital and was pronounced dead at 4:00 PM. The infant had sustained a fractured femur. It was unknown how or when the fracture occurred. There was no explanation for the cause of death of the infant, and there was no explanation for the fractured femur. Therefore, all persons legally responsible in the home, the mother and the maternal great aunt were named as subjects pending the outcome of the investigation.

On 2/22/15, the mother was holding the infant in the living room. The mother then dropped the infant, and he hit the floor. He stopped breathing. As a result the infant passed away. The mother and aunt gave conflicting stories that they laid the infant on the bed and the infant stopped breathing.

Executive Summary

The two-month-old male infant died on 2/22/15. As of 8/4/15, NYCRO has not yet received the ME's report. The allegations of the 2/22/15 report were DOA/Fatality, IG, and FX of the infant by the mother and maternal great aunt (MGA).

On 2/22/15, ACS initiated the investigation and learned that on 2/22/15, the mother and infant were in the MGA's home. At about 3:00 PM, the mother bathed and fed the infant. She swaddled him in a blanket and placed him on his stomach on the bed to sleep. His face was to the side to not obstruct his breathing. The mother went to the kitchen to wash dishes and she occasionally checked the infant. At about 3:40 PM, she saw he was not breathing. The mother's cousin and adult son were in the living room. The mother started CPR; her cousin placed the infant on the floor and continued CPR. The mother called 911. EMS arrived and transported the infant to the hospital.

The hospital SW said that in a conference with the attending physician, who had examined the infant, the physician noted that the infant's broken femur was caused maliciously due to his age and limited mobility. The mother denied having anything to do with the fracture and she said she did not observe anything was wrong with the infant. She also denied the infant fell and she said, if the infant had fallen, she would have taken him to the emergency room (ER) for medical care. The MGA said she left with both her children to go to the store. The MGA said she did not have knowledge about how the fractured leg occurred as the infant seemed active all day.

The LE staff said that there was no trauma to the infant and the infant seemed healthy. The fractures to the ribs were due to compressions during CPR. The right femur fracture was a clean break but the ME had no explanation as to how it occurred. The mother's explanation of what occurred that day was consistent. The ME stated that the infant had a broken leg and rib fracture, both recent injuries. The fracture could be a possibility from the CPR. The ME informed that information she (ME) obtained may relate to unsafe sleep with soft cushioning due to the infant co-sleeping and at the time of death, the mother reported he was alone in the bed lying on his stomach. Later, ACS inquired whether the infant sustaining a fall would change the decision and the ME noted not really but it provided some explanation and the infant's injury was consistent with blunt force trauma. The fracture was straight through to

the bone but jagged. The ME said that it had to be blunt force and a fall was plausible. Later, the ME noted that both the manner and cause of death were Undetermined.

On 6/29/15, ACS unsubstantiated the allegation of DOA/Fatality. ACS based the determination on the ME's statement that the manner and cause of death were undetermined. Documentation reflected although there was a high concern regarding the unsafe sleep habits and unexplained fracture it was not enough to link them to the cause of death.

ACS substantiated the allegations of IG and FX. ACS based their decision on the mother and MGA disclosing they co-slept with the infant and they were aware these were considered unsafe practices. The mother was educated by medical staff as well as ACS during the 12/19/14 investigation. Although the mother was informed about safe sleep practices throughout the investigation, she not only continued to co-sleep with the child; she swaddled him and laid him face down on the bed on the day he died. Developmentally the infant was unable to cause the injury to himself which meant that the injury to the femur would have had to be inflicted by one of his care providers. The mother had been residing at the home of the MGA for the month prior to his death. The MGA and the mother had care taking responsibilities for the infant. No viable explanation was provided on how the injury was sustained. According to EMS and ME, the infant's injury was not sustained during the EMS response.

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?** 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:
NA

Was the decision to close the case appropriate? Yes

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

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

Explain:
There were no surviving children in the household.

Required Actions Related to the Fatality

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

Issue:	Provision of Notice of Indication
Summary:	ACS documentation of the Event List did not reflect that the Notice of Indication was provided to the subjects of the fatality report.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	ACS documentation did not reflect that the child's second cousin who was a babysitting resource was interviewed nor the MGA's neighbors. ACS also did not address with the physician the belief that the fractured femur was caused maliciously.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency 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 Case Recording/Progress Notes
Summary:	There were notes that had an event date of 2/24/15 but were not entered until 4/22/15.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency 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: 02/22/2015 **Time of Death:** 04:00 PM

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 to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Other Household 1	Other	Alleged Perpetrator	Female	35 Year(s)

LDSS Response

ACS staff interviewed the SW who had obtained information from the mother. According to the SW, the mother stated she put him to sleep on the bed while she went to wash dishes. The mother's cousin arrived, went into the bedroom to check the infant and observed the infant not breathing. The cousin called out to the mother and attempted CPR. Later the mother also said she discovered the infant and began CPR. The SW said the mother and MGA said they had no knowledge or explanation about the fractured femur. The SW said the attending physician examined the infant, and assessed that the infant's broken femur was maliciously caused given the infant's age and limited mobility.

During the interview with the Specialist on 2/22/15, the mother said she laid the infant on the MGA's bed for a nap. She placed him on his stomach with a blanket over him and went to the kitchen to wash dishes. She checked him about three times while washing dishes. At about 3:40 PM, she went into the bedroom and saw he was unresponsive. She rolled him over and began CPR. She asked the cousin to assist and the cousin began chest compressions while she called 911. The mother said she did not have an explanation about how the child sustained the fractured femur. Later, on 2/23/15, the mother's account was different as she said she swaddled the infant and laid him stomach down. She began CPR, and then the MGA entered the home and took the infant to the living room while she called 911. The mother denied having anything to do with the fractured femur and she said she did not notice anything was wrong with the infant. Later, the mother said her cousin and the cousin's son were in the home at the time the infant was observed as unresponsive. She said she started CPR but then her cousin placed the infant on the floor and began CPR.

The MGA said she was not in the home at the time of the incident as she was at the store. The mother and infant had been staying with her for a two-week period. The MGA had a seventeen-year-old child who resided in the home and he presented well at the time of the visit. Later, on 2/23/15, the MGA said she left with both of her children and went to the store. The MGA did not have information about the infant's fractured femur. She became aware of the incident when she

returned to the home and observed the EMS had responded. Later, she said the mother's cousin was in the home with the adult son. She stated according to the mother's cousin, she was in the living room waiting for her to get back when she heard the infant cry. The mother's cousin did not enter the room. The MGA explained that the mother's cousin refused to speak with ACS or the police. The MGA said that while the infant had been in the home, he did not fall and had not been harmed. ACS referred the mother and MGA for a drug test. The mother and MGA did not complete the drug screening.

The LE staff said that the interviews with neighbors did not reveal new information. The ME said that the infant had a broken leg and rib fracture, both are recent. The ME had obtained information related to unsafe sleep with soft cushioning due to the infant co-sleeping and at the time of death, the mother said the infant was alone in the bed lying on his stomach. Later, ACS inquired whether the infant sustaining a fall would change the decision and the ME noted not really but it provided some explanation as there was none before and the infant's injury was consistent with blunt force trauma. The fracture was straight through to the bone but jagged. The ME said that it was likely blunt force but a fall was plausible. Later, the ME noted that the Manner and Cause of death are both Undetermined. The ME explained that the findings were Undetermined due to unsafe sleeping and fractures; although there was no direct link to the death, it was a high concern.

ACS substantiated the allegations of the report.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
018361 - Deceased Child, Male, 2 Mons	018363 - Other - Maternal Great Aunt, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated
018361 - Deceased Child, Male, 2 Mons	018362 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
018361 - Deceased Child, Male, 2 Mons	018363 - Other - Maternal Great Aunt, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
018361 - Deceased Child, Male, 2 Mons	018363 - Other - Maternal Great Aunt, Female, 35 Year(s)	Fractures	Substantiated

018361 - Deceased Child, Male, 2 Mons	018362 - Mother, Female, 25 Year(s)	Fractures	Substantiated
018361 - Deceased Child, Male, 2 Mons	018362 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Caretakers / Babysitters	☐	☒	☐	☐
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' documentation did not reflect that the child's second cousin who was a babysitting resource was interviewed.

There were progress notes that had an event date of 2/24/15 but were not entered until 4/22/15.

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	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☒	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☒	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The mother and MGA were referred for a drug test and the mother was referred to the Certified Alcohol and Substance Abuse Counselor (CASAC). On 3/16/15, the mother informed the Specialist that she did not feel she had any current service needs. The Specialist informed her that the documentation would be mailed with a listing of providers if she decided she wanted to engage in services.

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 children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother was not interested in bereavement counseling. The mother was referred for a drug test but did not attend.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	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?	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)
12/19/2014	3513 - Deceased Child, Male, 1 Days	3512 - Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	3513 - Deceased Child, Male, 1 Days	3512 - Mother, Female, 25 Years	Inadequate Guardianship	Indicated	

Report Summary:
The mother gave birth to an infant and she had no provisions for the child nor did she have the means to get them.

Determination: Indicated | **Date of Determination:** 02/17/2015

Basis for Determination:

ACS based the determination on the findings that the mother used marijuana while pregnant which resulted in the infant testing positive for marijuana. ACS unsubstantiated the allegation of IF/C/S as although the mother did not have an excess amount of provisions for the infant, the mother had the basic needs necessary for the child.

OCFS Review Results:
During a home visit on 1/8/15, ACS addressed with the mother infant safe sleep practices and the mother said that sometimes the slept in the bed alongside the infant. The mother informed the Specialist that there had been discussions about safe sleep habits. The Specialist reminded the mother that it was safest for newborn children to sleep in their own bed without anything in the crib or bassinet. The mother said she was aware of this information. ACS referred the family for PPRS. Also, ACS obtained medical record which showed on 1/13/15, the infant last had an appointment for an emergency room (ER) visit for a head bump. The infant was a "no-answer" and was not seen by a physician.

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

Issue:
Appropriate Application of Legal Standards (Abuse/Maltreatment)

Summary:
ACS inappropriately substantiated the allegation of IG. ACS based the decision on the mother utilizing marijuana while pregnant which resulted in the new born infant testing positive for the substance. In the Investigation Conclusion Narrative, ACS did not discuss the impact of the mother's drug use on the level of care she provided the infant.

Legal Reference:
SSL 412(1) and 412(2)

Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The ACS documentation did not reflect that ACS conducted follow up casework activities to obtain additional information about the 1/13/15 Emergency Room appointment for a head bump. The ACS case record did not reflect that the mother or medical staff were interviewed regarding this appointment.

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

Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency 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

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

Known CPS History Outside of NYS

There was no known history outside of NYS.

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: 02/04/2015

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: 02/04/2015

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

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐

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:				

The Family Services Stage (FSS) was opened on 2/4/15 and closed on 4/17/15. On 2/5/15, the Specialist made an appointment with the PPRS Liaison in order to refer the case for services. The FSS was closed as the child died on 2/22/15. There were no surviving children in the household.

Required Action(s)

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

Preventive Services History

As a result of the investigation of the 12/19/14 report, ACS found the mother required drug treatment and counseling to address marijuana misuse, parenting education, and referral for Early Intervention for the new born infant. On 2/4/15, ACS opened the Family Services Stage (FSS) to provide the family with preventive services. In the 2/4/15 Family Services Progress Notes, the Specialist documented that the mother gave birth to a newborn infant who tested positive for marijuana and the mother had limited resources. The Specialist noted concerns regarding the mother co-sleeping with the newborn infant. The Specialist noted that the infant sustained a bump on the head and the mother took the infant to the Emergency Room but did not wait for the infant to be seen.

On 2/5/15, the Specialist made an appointment with the PPRS Liaison in order to refer the case for services. Also, on 2/10/15, the Specialist visited the home, engaged the mother and provided her with written contact information for the Credentialed Alcoholism Certified and Substance Abuse Counselor. In addition, the Specialist observed the infant did not have marks or bruises.

Although the mother was referred for PPRS, the referral was pending at the time of the infant's death. According to ACS, the application for services was not signed. On 4/17/15, ACS closed the FSS as the child died on 2/22/15.

Family Assessment Service Planning (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent required FASP approved on time?	☒	☐	☐	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

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

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