Child Fatality Report

Report Identification Number: NY-16-107

Prepared by: New York City Regional Office

Issue Date: May 30, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	

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	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-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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 10/14/2016
Initial Date OCFS Notified: 10/19/2016

Presenting Information

On 10/19/16, the SCR registered a report alleging that on 10/11/16 the SC suffered an asthma attack and passed out. The SC was taken to Brookdale Hospital where he was placed on life support. The report alleged that prior to the SC passing out he complained to the mother that he was not feeling well. The report alleged the mother was not administering the prescribed medication for the SC and it was learned the medication found in the home had expired. The report stated the SC died on 10/14/16. The report stated the SC's death could have been prevented had the mother given the SC medication.

It was also alleged the SC's 14-year-old sibling had the same condition, and the mother was not following up on the child's medical needs.

Executive Summary

The SC was 16 years old when he was pronounced dead on 10/14/16 at 2:05 P.M. The SC was diagnosed with asthma when he was an infant and received treatment for his condition. There was no autopsy completed as it was determined by medical staff from Montefiore's Children's Hospital (MCH) the SC died of natural causes related to his medical condition.

The family had a history with ACS dating back to 2008, with 2 unfounded and 8 indicated reports. The reports focused on the mother's inability to follow up with the children's medical care and educational needs. A review of the history revealed the mother had untreated clinical and substance abuse issues. At the time of the fatality, the family had an open PPRS case dated 9/4/14 with HeartShare/St. Vincent's (HS/SV) Specialized Preventive Program.

On 10/14/16 and 10/19/16, the SCR received information concerning the death of the SC, however; no allegations were reported. Later, on 10/19/16, the SCR registered a report with allegations of DOA/Fatality of the SC and Lack of Medical Care of the SC and his 14-year-old sibling by the mother. ACS added the allegation of Educational Neglect of the 14- and 17-year-old siblings; and Lack of Medical Care of the 17-year-old sibling.

On 10/14/16, the PPRS CP learned of the SC's death when she attempted to contact the children at their schools. The PPRS CP and nurse proceeded to MCH and observed the 14-year-old sibling was accompanied by the MGM and the MA. There were no concerns documented by the CP pertaining to the 14-year-old sibling. The mother was not present as she was making funeral arrangements.

ACS responded to the additional information and contacted the family within the required time frame. The 20-year-old adult sibling and the 18-month old niece were residing in the home. The niece and the 14-year-old sibling were assessed to be safe in the home with their mothers. The 17-year-old sibling was assessed to be safe days later, MGM reported the child had been residing in her home for the past year.

According to the mother, on 10/11/16 at about 8:30 A.M., the SC was getting dressed for school when he complained to the mother that he could not breathe and collapsed. The mother said she screamed for help and a neighbor called 911. Days prior to the incident, the SC was getting over a cold/pneumonia.

ACS' EMS liaison confirmed a response to the home on 10/11/16 at 9:43 A.M. EMS found the SC unconscious; he was resuscitated by EMS before being transported to Brookdale Hospital (BH). The SC was stabilized and placed on life support, and three hours later, he was transported by ambulance to MCH. The mother stated she was informed at BH the SC had pneumonia.

According to the staff from BH, the SC was brought to the ER on 10/11/16 for cardiac arrest secondary to an asthma attack. The SC's prognosis was poor and he received extensive CPR prior to being transported to MCH.

On 10/25/16, ACS filed an Article 10 Neglect Petition with the Kings County Family Court on behalf of the surviving siblings. ACS was granted Court Ordered Supervision (COS).

On 12/20/16, ACS substantiated the allegations of the report. ACS determined the SC died because the mother did not administer the prescribed medication, and had not kept up with the SC's medical appointments. ACS also found the mother was not keeping medical appointments for the 14-year-old sibling and she had no medication for this child. The 17-year-old was had last seen his doctor in 2013. Lastly, ACS found the 14 and 17-year-old siblings continued to have poor attendance and the mother had not done anything to resolve this issue.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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

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

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

Explain:
The case remained open for services with Court Ordered Supervision.

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:	ACS did not list the MGM as a second caretaker in the RAP, although the 17-year-old sibling had been residing at her home for a year prior to the fatality. ACS did not properly respond to the questions listed on the RAP.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:	Appropriateness of allegation determination
Summary:	ACS did not add the MGM as a subject of this report with the allegation of educational neglect for the 17 year old as he was residing with her and she allowed him to stay home whenever he did not want to go to school.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/14/2016 **Time of Death:** 02:05 PM

Time of fatal incident, if different than time of death: 08:20 AM

County where fatality incident occurred: KINGS
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? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Getting ready to go to school

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

Total number of deaths at incident event:

Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Sibling	No Role	Female	21 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	14 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	17 Year(s)

LDSS Response

Following the fatality, ACS contacted the medical staff from BH, MCH, Wyckoff Heights Medical Hospital (WHMH), HS/SV, school staff and family members.

There was no NYPD involvement, as the SC died of natural causes.

According to the medical information gathered by ACS, the mother was not consistent in following up with the SC's and the 14-year-old sibling's medical care. ACS learned the mother was not properly filling the children's prescriptions. ACS found the SC had a prescription that had expired in November 2015. The 14-year-old sibling had no medication in the home because the mother had failed to fill a prescription. In addition, when the school staff was contacted they were unaware the 14-year-old sibling had a medical condition. It was not clear whether there was a medical action plan for the SC at the school.

ACS also learned the SC was treated at the WHMH's ER on 4/17/16; the SC was diagnosed with pneumonia. The SC was released on the same day and the mother was expected to follow up with the SC's doctor. The SW further indicated the SC was seen by a pulmonologist on 10/2/14 and was supposed to return in two months. However, the hospital had no record to reflect the mother brought the SC back.

ACS contacted the SC's doctor who stated the SC was last seen on 8/15/15; the doctor had no information about the SC's recent visit to the ER. The doctor noted he had not referred the SC or the 14-year-old children to a pulmonologist because he did not consider their condition as serious.

ACS conducted a thorough review of the SC's and surviving siblings' educational records with ACS' Education Advocate and noted the children's academic performance was negatively impacted due to their poor attendance. The review revealed the three children had a pattern of poor attendance dating back to kindergarten.

During the fatality investigation, it was evident the mother was not ensuring the children attended school on a regular basis. The MGM indicated the 17-year-old sibling was residing with her for the past year. The MGM reported the SC did not like to attend school because he was in a Special Education Class.

ACS interviewed the surviving siblings and all stated they were not home at the time of the incident. The 14-year-old sibling indicated she was at the MGM's home.

On 10/24/16, ACS held a Child Safety Conference (CSC) and focused on the children's poor medical care, educational neglect and the mother's lack of compliance with services.

Days prior to the CSC, ACS staff smelled alcohol on the mother's breath, but she denied any use of alcohol and/or drugs and refused to submit to a drug screening. The mother also stated that she did not need any mental health services as she had recovered from her condition. In addition to these issues, ACS learned the mother was in the process of eviction due to rent arrears. The findings of the CSC, prompted ACS filed an Article 10 Neglect Petition; ACS was granted COS.

After the Family Court intervention, the mother began working with service provider to address, rent arrears, medical and educational needs of the siblings, and the family's mental health services.

The report was indicated, and the case was transferred to ACS' Family Services Unit.

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 NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
031741 - Deceased Child, Male, 16 Yrs	031742 - Mother, Female, 40 Year(s)	Lack of Medical Care	Substantiated
031741 - Deceased Child, Male, 16 Yrs	031742 - Mother, Female, 40 Year(s)	DOA / Fatality	Substantiated
031744 - Sibling, Female, 14 Year(s)	031742 - Mother, Female, 40 Year(s)	Lack of Medical Care	Substantiated
031744 - Sibling, Female, 14 Year(s)	031742 - Mother, Female, 40 Year(s)	Educational Neglect	Substantiated
036083 - Sibling, Male, 17 Year(s)	031742 - Mother, Female, 40 Year(s)	Educational Neglect	Substantiated
036083 - Sibling, Male, 17 Year(s)	031742 - Mother, Female, 40 Year(s)	Lack of Medical Care	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine

All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☒	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
There was no NYPD involvement and the SC died at the hospital.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
10/24/2016	There was not a fact finding	Order of Supervision
Respondent:	031742 Mother Female 40 Year(s)	
Comments:	ACS requested court intervention and COS was granted.	

Services Provided to the Family in Response to the Fatality

Services	Provided After	Offered, but	Offered, Unknown	Needed but not	Needed but	N/A	CDR Lead to

	Death	Refused	if Used	Offered	Unavaliable		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 PPRS services continued and the family was also referred to ACS' family Preservation program to assist with the services listed.

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 immediate needs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate needs.

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?	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)	Status/Outcome	Compliance Issue(s)
06/07/2016	14961 - Deceased Child, Male, 15 Years	14962 - Mother, Female, 41 Years	Educational Neglect	Indicated	Yes
	14961 - Deceased Child, Male, 15 Years	14962 - Mother, Female, 41 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The report alleged the SC had been absent from school 70 days and the mother was unable to control or discipline the child. ACS learned from the CP that all three children were excessively absent and provided a report of their attendance to ACS.

ACS contacted the children's pediatrician who noted the SC and the 17 year old sibling were in need of medical follow up. The CPS had a consultation with the medical consultant (MC) and was advised to follow up with the pediatrician as to why the SC was no longer prescribed Flovent and why there had been no follow up with the SC seeing a pulmonologist. CPS did not follow up with obtaining a response.

Determination: Indicated **Date of Determination:** 08/04/2016

Basis for Determination:
ACS substantiated the allegation of the SC by the mother citing the child pattern of not attending school regularly and the mother's inability to rectify the problem. AC unsubstantiated the allegation of IG noting the mother provided the SC's basic needs such as food, clothing, shelter, and supervision.

The investigation revealed that the SC's two siblings had attendance problems of excessive absences and that the SC and the 17-year-old sibling were not up to date with the medicals. The allegation of EdN was not added for the siblings and the allegation of LMC was not added to the report for the SC and the 17-year old sibling.

OCFS Review Results:
NYCRO's review revealed this was not a thorough investigation. ACS did not contact the source or the school staff. Report of the children's attendance were provided by the CP who indicated all three children had excessive absences. CP attributed the problems with the attendance of the SC and the 13-year-old sibling due to the children's medical condition. The documentation did not reflect the PS followed up with the MC questions or recommendations of the recent investigations. The safety assessments and the RAP were not completed properly.

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

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
Issues of EdN and LMC were revealed, however, ACS did not add allegations as it pertained to each child. Information

concerning the SC's asthma treatment was discussed with a MC, but ACS did not follow up with the directions provided by the MC. No contact was made with the children's schools.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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 did not make contact with the source, and only one attempt was made via telephone.

Legal Reference:

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

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:

The questions in the RAP were not answered according to the information documented in the investigation.

Legal Reference:

18 NYCRR 432.2(d)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:

Timely/Adequate Seven Day Assessment

Summary:

The safety factors selected did not reflect how the mother's actions or lack thereof impacted her ability to provide for the children's or her inability to care or protect the children .

Legal Reference:

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

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:

Predetermination/Assessment of Current Safety and Risk

Summary:

The safety factors selected did not reflect how the mother's actions or lack thereof impacted her ability to provide for the children or her inability to care, supervise and/or protect the children.

Legal Reference:

18 NYCRR 432.1(aa)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/31/2016	14946 - Sibling, Female, 13 Years	14947 - Mother, Female, 40 Years	Educational Neglect	Indicated	Yes

Report Summary:

The report alleged the 13-year-old sibling missed 39 days of school and was failing academically. The family reported the school staff did not update the attendance records when the sibling arrived late to school.

ACS contacted the HS/SV's CP on 4/7/16 who stated a HV was made on 4/6/16 and there were no safety concerns in the home. The CP based this statement on the conditions of the home and the mother's demeanor. It was noted the HS/SV was in the process of closing the case. ACS did not question the lack of success with monitoring the children's health and educational issues due to their lack of attendance; which was the primary reason for the referral to HS/SV.

Determination: Indicated | **Date of Determination:** 04/11/2016

Basis for Determination:

ACS substantiated the allegation of Educational Neglect of the 13-year-old sibling by the mother. ACS noted the mother was not ensuring the child attended school regularly, and therefore the child was failing academically.

OCFS Review Results:

NYCRO's review found this investigation was not thorough. ACS did not make relevant collateral contacts concerning the children's attendance or medical information. ACS did not follow up on the family's explanation concerning the 13-year old sibling's attendance. ACS documented the children's medication, but did not document whether the SC or the 13-year-old sibling were taking the medications as prescribed. ACS did not include a summary to explain the outcome of the FTM scheduled for 3/29/16 or whether there was any follow up of the MC's preliminary recommendations dated 3/23/16. ACS closed the investigation in 11 days.

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

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

ACS completed the investigation in 11 days and did not fully explore the family's circumstances. The investigation was allegation-focused and did not include a review of the outcomes of the recent meetings held on 3/23/16 or 3/29/16 from the recently completed investigation. These meetings were to focus on the EdN, LMC and the mother's non-compliance.

Legal Reference:

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:

Failure to Provide Notice of Indication

Summary:

The CONNECTIONS event list did not reflect there was a NOI issued to the mother.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
Failure to provide notice of report
Summary:
The CONNECTIONS event list did not reflect a NOE was issued to the mother.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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 did not respond to the questions in the RAP. The investigation documentation did not reflect the questions were addressed.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
Review of CPS History
Summary:
ACS did not document a thorough review of the family's history to utilize the history when conducting this investigation.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
The documentation did not reflect the source of the report was contacted to address the allegation of the report and/or gather additional information. There were also no relevant contact with the children's pediatrician, school staff or medical specialists.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/15/2016	14876 - Deceased Child, Male, 15 Years	14875 - Mother, Female, 39 Years	Educational Neglect	Indicated	Yes
	14877 - Sibling, Male, 17 Years	14875 - Mother, Female, 39 Years	Educational Neglect	Indicated	

Report Summary:
The SCR report alleged the SC was absent 38 days from school and as a result he was failing academically. The family had an open FSS with the HS/SV. The mother's adult daughter and her infant were residing in the home.

ACS contacted the CP who indicated the agency was in the process of closing the case due to the mother's non-compliance and not making the children accessible to the CP or he nurse. The CP also indicated the 17-year-old sibling's attendance was "horrible."

The CPS had a MC on 3/23/16 and there were preliminary recommendations made to address the SC and the 13-year-old sibling's medical issues. There was also a JHV planned with the CP and ACS to have a FTM on 3/29/16.

Determination: Indicated | **Date of Determination:** 03/25/2016

Basis for Determination:
ACS substantiated the allegations of the report against the mother for the SC. ACS also added and substantiated the allegation of educational neglect of the 17-year-old sibling by the mother. ACS cited the mother was not ensuring that the children attended school and as a result the children were failing academically. ACS did not add any allegations concerning the 13-year-old sibling.

OCFS Review Results:
NYCRO's review found this was not a thorough investigation. There was no discussion with the children's pediatrician, medical specialists or school staff. Although there were discussions and concerns about the SC's and the 13-year-old sibling's medical needs. There were no allegations concerning the LMC and the 13-year-old sibling remained with no role in the report. The investigation was closed prematurely, in 10 days, and there was no documentation in the investigative stage to show the outcome of the MC recommendations or the JHV. The mother mentioned she was involved in a car accident and was unemployed, but this was not properly explored.

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

Issue:
Failure to Provide Notice of Indication

Summary:
CONNECTIONS event list did not reflect a NOI was issued to the mother.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:

The investigation documentation did not reflect the questions in the RAP were addressed; and the responses for the questions did not reflect the case circumstances.

Legal Reference:

18 NYCRR 432.2(d)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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 Investigation

Summary:

The CPS had a MC on 3/23/16 and there were preliminary recommendations for ACS to address the SC's and the 13-year-old sibling's medical issues. There was also a JHV planned with the CP and ACS to have a FTM on 3/29/16. ACS completed this investigation in 10 days without following up on the MC's recommendation or documenting the outcome of the JHV.

Legal Reference:

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:

Predetermination/Assessment of Current Safety and Risk

Summary:

ACS selected safety decision (2) which states safety factors were present but did not rise to the level of immediate or impending danger of serious harm. However, the comments documented for the safety factors selected did clearly state how the mother's actions or lack thereof impacted her ability to meet the children's needs.

Legal Reference:

18 NYCRR 432.1(aa)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/04/2014	14873 - Sibling, Female, 12 Years	14874 - Mother, Female, 38 Years	Inadequate Guardianship	Unfounded	Yes
	14873 - Sibling, Female, 12 Years	14874 - Mother, Female, 38 Years	Lack of Medical Care	Unfounded	
	14871 - Deceased Child, Male, 14 Years	14874 - Mother, Female, 38 Years	Lack of Medical Care	Unfounded	
	14872 - Sibling, Male, 15	14874 - Mother, Female,	Inadequate	Unfounded	

Years	38 Years	Guardianship	
14871 - Deceased Child, Male, 14 Years	14874 - Mother, Female, 38 Years	Inadequate Guardianship	Unfounded
14872 - Sibling, Male, 15 Years	14874 - Mother, Female, 38 Years	Lack of Medical Care	Unfounded

Report Summary:
The family had an open case with HS/SV; however, the mother was not in compliance with the agency's appointments and did not make the children available.

The report alleged the mother's 3 children were medically fragile and had to be seen on a regular basis. However, it was alleged the mother had last taken the children for their medical appointment on 10/30/11. ACS learned the 15-year-old sibling was not medically fragile.

The adult sibling (19) was residing in the home and pregnant. The 15-year-old was living with the MGM per a family arrangement.

Determination: Unfounded | **Date of Determination:** 02/04/2015

Basis for Determination:
ACS unsubstantiated the allegations of LMC and IG against the mother for the three children. ACS documented the children were attending school, receiving medical care, and seeing a pulmonologist. This was not consistent with the MC's findings dated 1/27/15. The MC found inconsistency with the information provided by the family and had concerns the children's doctor had no knowledge about the children's prescription. The MC concluded the mother did not take the children to the pulmonologists appointments. The MC noted the medical condition was controllable and school absence of any significance was unnecessary.

OCFS Review Results:
This was not a thorough investigation as it did not appear ACS utilized information from the MC or the school staff when making the determination of the allegations. The MC found the information provided by CPS for the 1/27/15 consultation "confusing" with several "inconsistencies." The safety assessments and the RAP were not completed properly. The family continued to receive services from the HS/SV; however, it was not clear how these services would help the family as the mother did not seem convinced about accepting services.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
ACS selected the safety decision which reflects safety factors were present that did not rise to the level of immediate or impending danger of serious harm. However, the safety factor selected was concerning the family's history. During this period, ACS did not document any information to support the history presented reflected current safety concerns.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
At the determination, ACS selected safety decision which reflected safety factors were present but did not rise to the level

of immediate or impending danger of serious harm. The safety factors selected were concerning the family's history and the children's vulnerability. The comments documented did not support the selected safety factors.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:

Appropriateness of allegation determination

Summary:

ACS did not utilize the information received from collateral and MC when making their determination of this report. Also, each of the children's circumstance was different; therefore, the narratives should have been completed individually.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:

The responses for the questions in the RAP were not based on the circumstances. The investigation documentation did not reflect the each question was explored.

Legal Reference:

18 NYCRR 432.2(d)

Action:

ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/22/2014	14861 - Deceased Child, Male, 13 Years	14864 - Mother, Female, 37 Years	Educational Neglect	Indicated	Yes
	14862 - Sibling, Female, 11 Years	14864 - Mother, Female, 37 Years	Educational Neglect	Indicated	
	14861 - Deceased Child, Male, 13 Years	14864 - Mother, Female, 37 Years	Lack of Medical Care	Indicated	
	14862 - Sibling, Female, 11 Years	14864 - Mother, Female, 37 Years	Lack of Medical Care	Indicated	

Report Summary:

The report stated the SC and his 11-year-old sibling were excessively absent from school. The BM explained the children suffered from chronic asthma which impacted on their school attendance.

CPS met with ACS' medical consultant (MC) who had concerns about the number of asthma attacks the children had . The MC stated the children's asthma was controllable if they were properly medicated. There were concerns the BM was not educated properly on how to medicate the children to prevent the asthma attacks. The MC also had concerns about the medical care the children were receiving from the pediatrician. It was not clear whether the MC discussed this matter directly with the pediatrician.

Determination: Indicated | **Date of Determination:** 07/17/2014

Basis for Determination:
ACS confirmed the information reported to the SCR and substantiated the allegation of EdN of both children by the BM. ACS also added and substantiated the allegation of LMC for both children as the BM was not following up with treatment for their medical condition.

OCFS Review Results:
The investigation was not thorough, the Specialist did not document an observation of the medication in the home, details of the refill dates or who prescribed the medication to clarify and further investigate the MC's concerns. The MC noted the BM was not appropriately administering the medication to the children . ACS did not issue the appropriate notices and did not properly complete the safety assessments. A FSS was opened to refer the family to PPRS.

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

Issue:
Failure to provide notice of report
Summary:
The CONNECTIONS event list did not reflect the NOE was issued to the mother.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
Failure to Provide Notice of Indication
Summary:
The CONNECTIONS event list did not reflect the NOI was issued to the mother.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
Timely/Adequate Seven Day Assessment
Summary:
The safety factors selected were not supported by the comments.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who

attended, and 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' investigation did not gather information to properly respond to the questions listed in the RAP.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The safety decision selected noted there were safety factors that placed the children in immediate and impending danger of serious harm; however, there were no safety factors selected to support this decision. The case type selected for the safety assessment was incorrect.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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 Investigation
Summary:
The documentation did not reflect that ACS examined the medication in the home, refill dates or who prescribed each of the medication for each child. It was not clear how the MC' s review were used for the investigation as he had some concerns.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/30/2013	14845 - Sibling, Female, 17 Years	14846 - Mother, Female, 36 Years	Inadequate Guardianship	Unfounded	Yes
	14845 - Sibling, Female, 17 Years	14846 - Mother, Female, 36 Years	Educational Neglect	Unfounded	

Report Summary:
The report stated the 17-year-old sibling had been absent 70 days since the beginning of the school year and was failing

all her classes. The report also noted the BM was aware of the situation, but failed to resolve the problem.

ACS confirmed the other children; including SC had average grades; however, had missed about 25 to 30 days of school.

The investigation revealed issues that suggested the BM had poor management of the family's funds as she owed 18,000 in rent arrears. The BM also reported she had recently ended a 2-year relationship with a boyfriend who she had verbal and physical altercations.

Determination: Unfounded | **Date of Determination:** 05/31/2013

Basis for Determination:
ACS unsubstantiated the allegations of EdN and IG against the mother for the 17-year-old sibling. ACS' narrative to support the determination for EdN notes collaterals stated the BM had been "addressing this issue." However, the documentation did not reflect the BM had planned for the sibling's education prior to ACS' involvement.

ACS' narrative to support the determination of IG noted the BM was always aware of the SC's whereabouts of the child and was providing adequate supervision. However, the sibling would often stay at her girlfriend's or an aunt's homes. ACS did not contact these individuals to assess the condition of their home or the girlfriend's information.

OCFS Review Results:
NYCRO's review revealed this was not a thorough investigation. ACS did not utilize the 60-day period to explore issues concerning the SC's (of fatality) and other siblings' attendance, rent arrears or domestic violence. ACS did not make relevant collateral contacts to further assess the family's functioning and/or the risk and safety of the children as it related to the BM's ability to care for them. Based on the case documentation, there were no safety factors; however, many issues of concerns were not adequately explored. Therefore, the risk assessments were not properly completed. There was not a detailed review of the family's child welfare history.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
ACS selected a safety decision that noted safety factors existed but did not place the children in imminent or immediate danger of serious harm. However, the safety factors listed were not consisted with the case documented.

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

Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
Predetermination/Assessment of Current Safety and Risk

Summary:
ACS selected a safety decision that noted safety factors existed but did not place the children in imminent or immediate danger of serious harm. However, the safety factor listed was not consisted with the case documentation. The RAP was not properly completed as the documentation did not reflect the answered to the question were properly explored.

Legal Reference:
18 NYCRR 432.1(aa)

Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
Appropriateness of allegation determination
Summary:
ACS' basis to support the determination was not consistent with the information gathered during the investigation. There was credible evidence to support the allegations of EdN and IG of the 17-year-old sibling.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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 Investigation
Summary:
ACS did not utilize the 60-day period to explore issues concerning the SC's (of fatality) and other siblings' attendance, rent arrears or domestic violence. In addition, relevant collateral contacts were not made.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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:
Review of CPS History
Summary:
The documentation of actions or lack thereof reflects there was not a thorough review of the family's history. ACS did not consider the history throughout the investigation or when assessing the mother's ability to care for the children or making a determination.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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 did not contact the 17-year old sibling's girlfriend , the aunt, landlord or CAMBA who the mother report was assisting her with the rent arrears/housing.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

[redacted]

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

From 2/26/08 through 5/22/12, the SCR registered 4 reports listing the mother as the subject. The four reports were indicated. The allegations of these reports were PD/AM, EdN, LOS and IG of the SC and his siblings. In some reports, the father was also listed as a subject; however, he died on 3/27/11.

These reports were investigated by the Brooklyn Field Office who found credible evidence to indicate the reports. Most reports focused on EdN of the oldest sibling (now adult). However, history reflects the mother was negligent regarding the attendance of all the children.

Known CPS History Outside of NYS

There was no known CPS history outside 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: 09/04/2014

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?	☒	☐	☐	☐

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 case was referred to HS/SV' to monitor the children school attendance and medical needs.

Required Action(s)

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The HS/SV did not add the MGM as a second caretaker. The 17-year-old sibling had been living with the MGM and the progress notes reflected the HS/SV was making visits to the MGM's home.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must request a correction action plan from the HS/SV.

Preventive Services History

ACS referred the family for PPRS in 2014 due to the mother's inability to follow up with giving the SC and the younger sibling their asthma medication as prescribed, and not following up with taking them to see a pulmonologist. The children's health was impacting the children's school attendance and their academic performance.

On 9/4/14, a case was opened with HS/SV's Special Services' Program. At the time of the fatality, the case remained open with PPRS. However, the review of the FSS reflected the family was not compliant with services as the mother had not been engaged with the agency and there was no closed monitoring of the children's condition or their home. After the SC's death, the case remained open.

On 5/13/13, the family was referred to Catholic Charities Neighborhood Services to monitor the children's school attendance and mental health. However, the case was closed due to the mother's refusal to accept services.

On 4/19/12, the family was referred to the Puerto Rican Family Institute due to the children's poor attendance, death of the father, and mother's drug history. The case was closed 1/4/13.

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