Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-114

Prepared by: New York City Regional Office

Issue Date: Apr 12, 2022

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Richmond
Gender: Female
Date of Death: 10/29/2021
Initial Date OCFS Notified: 10/29/2021

Presenting Information

The SCR report alleged on 10/29/21, the mother was walking with her two children, a 2-month old, and the 2-year-old subject child. The mother was walking ahead of the subject child and was not paying attention to the child. As a result, the subject child was struck by a vehicle. The subject child arrived at the hospital at 2:25PM by EMS. The hospital tried to resuscitate the subject child but efforts were not successful. The subject child was pronounced dead at 3:24PM. The roles of the 2-month-old and 11-yo surviving siblings were unknown.

Executive Summary

The 2-year-old female subject child (SC) died on 10/29/21. As of 3/30/22, NYCRO had not received a copy of the ME's report. Preliminarily, the ME verbally reported the cause of death was Blunt Force Injury of Torso. The manner was Accident.

At the time of the SC's death, the family had an open ACS investigation that was registered on 10/25/21. On 10/29/21, ACS was in the process of investigating the report when the SCR registered a report that included allegations of DOA/Fatality and IG of the SC by the SM. Later, ACS added allegations of IG of the two SSs by the SM.

ACS' investigation revealed the mother walked ahead of the 2-year-old child while pushing the stroller with the two-month-old child. A Ford SUV struck the subject child a few feet back. The SUV's driver did not observe the SC due to the size of the vehicle and the SC's height.

LE spoke with the driver who appeared distraught over the incident. The driver said she had the green light. The driver saw the SM and allowed her to walk; however, she did not see the SC. The driver stated the SM appeared distracted on the phone. LE spoke with collaterals such as workers from two local stores, who corroborated to the driver stating the SM was on the phone and not properly supervising the SC. Later, LE said he estimated the SC was 8-10 feet behind the SM. LE spoke to collaterals who were present during the incident, and they reported the light was green when the family walked in front of the SUV. Although the driver had the right of way, the driver permitted the family to cross the walk path.

On 10/30/21, ACS conducted an emergency removal of the two SSs.

On 11/1/21, the Forensic Pathology Coordinator with the ME's office said the cause of death was Blunt Force Injury of Torso and the manner of death was Accident.

On 11/1/21, ACS filed an Article Ten Abuse petition in family court naming the SM as the respondent. The SSs were placed in foster care. An OP was issued. The SM was to have ACS supervised visits or visits supervised by an approved resource.

On 11/3/21, ACS opened a service case.

On 11/5/21, a conference occurred. ACS discussed the service plan which included a clinical health evaluation, parenting programs, bereavement counseling for the SM and 11-yo, and early intervention for the 2-month-old. Later, the foster care agency said the SM was in bereavement counseling and the 11-yo was in a program at school to receive the service.

On 12/27/21, ACS substantiated the allegations of DOA/Fatality and LS of the SC and IG of the SC, 2-month-old and 11-yo by the SM on the basis that some credible evidence existed. LE told ACS the SM was observed on her cell phone and pushing a stroller while the SC walked about 8-10 feet behind her. According to LE, the SM was observed crossing a parking lot entrance and exit against the light when the SC was struck by a vehicle exiting the parking lot.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
NA

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:
On 11/3/21, ACS opened a service case. The SSs were placed in foster care.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Notes were not entered contemporaneously. For example, an event occurred on 11/5/21 but was not entered until 12/21/21.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this

	fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The documentation did not reflect ACS interviewed the driver of the SUV. In addition, the documentation did not reflect that EMS was interviewed regarding the incident.
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: 10/29/2021 **Time of Death:** 03:24 PM

Time of fatal incident, if different than time of death: 01:45 PM

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? Yes
Time of Call: 01:45 PM
Did EMS 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: Walking with mother and sibling.

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☒ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **Mo was on her cell phone. The SC walked behind.**

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age

Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	11 Year(s)

LDSS Response

On 10/29/21, the hospital Dr. told ACS the medical team began to resuscitate the SC and additional testing was in the process but the SC "coded." The SC was pronounced dead at 3:24 PM.

On 10/29/21, the SM was interviewed at the hospital. The SM reported she did not have any contact with the father of the SC and the father of the 11-yo SS, but she had contact with the father of the 2-month-old. The SM denied substance use. ACS observed the 2-month-old SS at the hospital. The SM reported that the SC, 2-month-old, and herself went to obtain Halloween costumes and then pizza. When they finished eating, they were walking to the bus stop where they saw the vehicle. The vehicle permitted her to cross and then hit the SC. SM described the vehicle hitting the SC like a "speedbump." The SUV hit the SC and then went on top of her where the SM grabbed the SC underneath the vehicle. SM did not call 911 as there was EMS and a Dr. present during the incident who contacted 911. EMS transported the SC to the hospital.

On 10/29/21, ACS visited the home and interviewed the 11-yo SS. The 11-yo said he was in school, but the SM told him the SC was run over by an SUV and the driver yelled at her. He denied ever being left alone. He did not report drugs/alcohol use in the home.

The ACS documentation reflected the supervisor spoke with Assistant District Attorney (ADA). A video of the SC being hit by the vehicle was sent from the District Attorney's (DA) office to ACS CPS Team to review. The SM was several feet away pushing the stroller and looking down at her phone. The SC was not in sight. The SM continued to walk several feet ahead. The SC then ran toward the SM's direction behind the SM as the SM was walking forward. The SC was run over by the SUV with the left front tire. The SM ran back, left the stroller, and picked up the SC from underneath the SUV. Several passersby ran over to help. One passerby stood with the 2-month-old in the stroller. There were many people assisting the SM with the SC.

On 10/30/21, ACS conducted a visit to the home of the SC's godfather to complete an expedited home study. The godfather lived in the home with his paramour and two children; a 3-yo and 6-month-old male. There were no safety concerns during the visit.

On 11/1/21, ACS received an update from the DA's office. LE reported the driver of the vehicle showed no signs of intoxication. The driver indicated she did not see the child at the time of the incident.

On 11/3/21, the father of the 2-month-old said he wanted visitation as he was aware his home could not be cleared due to his inability to provide information. He said the roommate did not consent to share his information.

On 11/3/21, ACS visited the foster home and saw the two SSs. ACS observed the 2-month old's old abrasion and it appeared to be in the healing stages. The FM stated the two children were adjusting well. Later, the SSs were moved to a kinship placement.

On 12/21/21, ACS spoke with a school staff member who said the 11-yo was receiving speech services and counseling as needed. The SS was not showing signs or behavioral changes. The SS was referred to a service provider located at the school and was in the process of providing individual counseling.

ACS indicated the report.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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 referred to 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
059999 - Deceased Child, Female, 2 Yrs	060000 - Mother, Female, 29 Year(s)	DOA / Fatality	Substantiated
059999 - Deceased Child, Female, 2 Yrs	060000 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
059999 - Deceased Child, Female, 2 Yrs	060000 - Mother, Female, 29 Year(s)	Lack of Supervision	Substantiated
060001 - Sibling, Male, 2 Month(s)	060000 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
060002 - Sibling, Male, 11 Year(s)	060000 - Mother, Female, 29 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?	☐	☒	☐	☐
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:
The documentation did not reflect that EMS was interviewed regarding the incident.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
On 11/3/21, ACS opened a service case. The SSs were placed in foster care.

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
The documentation reflected that on 10/31/21, ACS removed the two SSs from the SM's care due to continuous concerns of supervision surrounding the CHN. On 11/1/21, filed an Article Ten Abuse petition in Richmond County Family Court (RCFC) naming the SM as the respondent. The RCFC granted the remand of the SSs with an OP against the SM. The SSs were placed into foster care.

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:**
11/01/2021	There was not a fact finding	There was not a disposition
Respondent:	060000 Mother Female 29 Year(s)	
Comments:	On 11/1/21, ACS filed an Article Ten Abuse petition in Richmond County Family Court naming the SM as the respondent. The SSs were placed in foster care.	

Have any Orders of Protection been issued? Yes	
From: 11/01/2021	**To:** Unknown

Explain:
According to ACS, ACS requested a full stay away OP on 11/1/21, but the request was denied and a limited OP was issued, which permitted the SM to have ACS supervised and agency approved resource supervised visits with the CHN. On 2/3/22, the OP was modified to allow expanded visitation in the form of sandwiched visits and unsupervised visitation (which included overnights).

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
On 11/18/21, ACS submitted the authorization for burial assistance. On 12/6/21, the foster acre agency referred the 2-month old to Early Intervention. The documentation reflected ACS referred the SM for a clinical health evaluation and parenting classes. The foster care agency informed ACS the SM was in bereavement counseling and the 11-yo was in a program at school to receive bereavement.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The SS's were placed in foster care. On 12/6/21, the foster care agency referred the 2-month old to Early Intervention.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The documentation reflected ACS referred the SM for a clinical health evaluation and parenting classes. ACS submitted the authorization for burial assistance. The foster care agency informed ACS the SM was in bereavement counseling and the 11-yo was in a program at school to receive bereavement counseling.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/25/2021	Sibling, Male, 2 Months	Mother, Female, 29 Years	Internal Injuries	Unsubstantiated	No
	Sibling, Male, 2 Months	Mother, Female, 29 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 2 Months	Mother, Female, 29 Years	Swelling / Dislocations / Sprains	Unsubstantiated	
	Sibling, Male, 2 Months	Mother, Female, 29 Years	Lack of Supervision	Substantiated	
	Deceased Child, Female, 2 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Months	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 11 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The SCR report alleged that on 10/25/21, while in the care of the SM, the 2-month old sustained a laceration on his mouth, deep scratches to his throat and tongue, swelling to his left eye, swelling to the left side of his head, and abrasions to the right and left side of the head, and underneath the eye. When the SM noticed the blood in the 2-month old child's mouth, the SM waited approximately one hour before calling for emergency medical services. The SM was aware the 2-month old required immediate medical attention and failed to follow through. There was no explanation for these injuries making them suspicious. The SM had access to the 2-month-old child and was therefore the subject.

Report Determination: Indicated | **Date of Determination:** 12/23/2021

Basis for Determination:
ACS documented there was credible evidence that the SM failed to provide an appropriate level of supervision, resulting in the death of the SC. The 2-month-old was observed with multiple scalp and mouth lacerations. The SM fell asleep from 8:00AM until 2:00PM and failed to provide appropriate supervision for the child. The 2-month-old sustained eight lacerations in different stages of healing to the chest, inside his mouth, and top of his head without an explanation.

OCFS Review Results:
The investigation was initiated timely, and a home visit was made. The source of the report was contacted. A CPS history check, and 7-day Safety Assessment was completed timely. Notice of Existence letters were provided timely. The investigation revealed credible evidence to substantiate the allegations.

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

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

The SM was known to the SCR and ACS as a subject in three reports dated: 3/22/12, 1/1/17, and 2/8/18. The allegations of the 3/22/12 report were IG, PD/AM, and IF/C/S of the now 11-yo SS by the SM. On 5/21/12, ACS unfounded and closed the report. The family was referred to community based services only.

The allegations of the 1/1/17 report were IG and PD/AM of the now 11-yo SS and 9-yo CH (cousin) by the SM (who was listed as an aunt), Parent Substitute, and mother (of the now 9-yo CH, also the MA). On 3/2/17, ACS indicated the report.

The allegations of the 2/8/18 report were IG and L/B/W of the now 11-yo SS by the SM and Parent Substitute. On 4/13/18, ACS substantiated the allegations of IG and L/B/W by the Parent Substitute and unsubstantiated the allegations of IG and L/B/W by the SM. The investigation was closed and the family was referred to community based services only.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Preventive Services History

During the 1/1/17 investigation, ACS opened a service case on 2/9/17 for PPRS services. ACS uncovered family conflict which warranted a referral for services. The initial FASP reflected that the service plan was case management services. The notes reflected the SM and 11-yo CH entered the shelter system. The PPRS agency documented the CP was unable to conduct a visit in July 2017. On 8/24/17, PPRS staff spoke with the shelter CM who confirmed the SM and CH were in the shelter. The family moved to another borough and the service case was closed on 9/22/17.

During the 2/8/18 investigation, ACS opened a service case on 4/12/18 and closed it the same day. No FASP's were completed and there was no Family Service Progress Notes.

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