Child Fatality Report

Report Identification Number: NY-17-024

Prepared by: New York City Regional Office

Issue Date: Oct 06, 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	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 03/07/2017
Initial Date OCFS Notified: 03/07/2017

Presenting Information

The SCR registered two separate reports regarding the fatality. These reports were dated 3/7/17 and 3/8/17.

The 3/7/17 report alleged that from 2/17/17 through 2/24/17, the SC was hospitalized at the Mount Sinai Hospital Pediatric Intensive Care Unit for failure to thrive. The report also alleged the SC was diagnosed with failure to thrive as a result of neglect while in the care of the SM and SF. On 3/7/17, the SC died as a result of failure to thrive.

The 3/8/17 report alleged the SC and SS were removed from the parents' care on 2/23/17. The CHN were placed at the Children's Center with ACS from 2/23/17 until 3/6/17. The SC was diagnosed as failure to thrive, but gained weight and was doing well at the center. The SC was placed into foster care with the FM on 3/6/17. The SC died in the care of the FM on 3/7/17. The report also alleged that on 3/7/17, the SC woke up crying around 5:00 AM. The FM changed his diaper, fed him and put him back to sleep on his stomach. The SC woke up again, crying around 8:00 AM. The FM again changed his diaper, fed him and placed him to sleep on his stomach. Around 11:30 AM, the FM checked the SC and realized he was not moving or breathing. The FM called 911 and the SC was transported to Jamaica Hospital where he was pronounced dead at 1:25 PM. The cause of death was unknown and there was no adequate explanation for the SC's death.

Executive Summary

ACS initiated the investigation into the death of the 2-month-old male SC on 3/7/17, the date of his death. The autopsy listed the cause of death as Positional Asphyxia and the manner of death was Accident (Prone and face down position on folded blanket in crib). The contributing cause of death was listed as premature birth; recent viral respiratory infection.

Prior to the SC’s death, ACS filed an Article 10 Abuse petition on 2/22/17 against the parents on behalf of the SC and SS, and a removal was granted. The SC had a pre-existing medical condition, and was hospitalized from 2/11/17 to 2/27/17. He was discharged to the ACS Children’s Center (ACC), where he and the SS were initially placed. On 3/6/17, both CHN were placed with the FM under the supervision of the HeartShare St. Vincent’s Agency.

ACS learned the timeline of events surrounding the fatality. The FM said the SC and SS were dropped off sometime between 11:30 PM and 11:45 PM on 3/6/17. At about 1:00 AM, the FM, her adult daughter and her 15-year-old CH went upstairs to feed the CHN. After feeding the CHN, FM placed the CHN to sleep. The SC slept in the car seat, and the SS was placed in the crib. At about 5:00 AM, the SC awoke, and FM changed and fed him. The SS woke at about 9:00 AM. The FM took the SS out of the crib and brought him downstairs. The FM then placed the SC in the crib, first on his back, then switched him to his stomach. At about 12:00 PM, she checked on the SC. She felt something was wrong as he did not respond when she tapped his back. She picked up the SC and the foster care agency (FCA) called her simultaneously. The FM told the FCA staff that something was wrong, and staff told her to call 911 which she did. ACS asked the FM why she did not have the playpen upstairs. The FM said she had other cribs and she planned to put them up on 3/7/17 since they brought the CHN last night. Documentation reflected that ACS revisited the sleeping arrangements with the FM. The interviews of the ACS transportation workers conducted on 3/17/17 and 3/20/17 did not reflect ACS checked for a safe sleep environment. The male ACS transportation worker said he received a request by pre-placement on 3/6/17 to transport the two children to the foster home. The female ACS transportation worker said the children did not have any medication, they only had the medical package.

On 3/7/17, ACS offered the SM bereavement counseling, though the SM reported she had contacted her own counselor. ACS discussed burial plans. SM said she was provided several referrals for assistance by hospital staff.

On 3/7/17, LE said there were no arrests or criminal charges based on the preliminary information gathered. The SC was seen by the Dr. who ruled out physical abuse. On 3/8/17, the SF informed ACS that he was instructed by his attorney not to speak with ACS.

On 3/16/17, a child safety conference (CSC) occurred regarding the SS. The SS remained in FC and the FCA planned to follow up to have him evaluated for Early Intervention (EI) services. Though the SS remained in FC, he was relocated to a new foster home given the concerns under investigation. The only other foster CH in the home was 18 years old, and ACS assessed her to be safe. ACS noted they would not request re-placement unless safety concerns for her became known during the investigation, which they did not.

ACC nursing staff were interviewed on two separate dates. It was reported the SC was brought to their facility upon discharge from the hospital. He was discharged without any specific medical needs or medications except for a topical cream. When he arrived at the ACC, he weighed 7 pounds 12.5 ounces. During his time at the ACC he maintained normal vitals, and he was not weighed as this was not protocol. The last time the SC was seen by the nurse was at 10:15 PM on 3/6/17 when he was ready for placement in the foster home. The SS had medication to be brought with him to the foster home. It was ACC protocol to medically assess CHN prior to leaving.

ACS learned of concerns surrounding the FM’s CPS history, and questioned the appropriateness of the FC placement. The FM had history of being a respondent in neglect proceedings, had a CH removed from her care, and had other CHN involved with COS. The ACS documentation showed the FM had been a foster parent since 1990. ACS met with the FCA to discuss the concerns. The FCA informed ACS they were unaware of the information presented to them about the FM’s additional CPS history. The FCA was unable to locate any information in their records about this, and stated they would continue to research the issue. The last SCR clearance of the FM was 1/22/09 with no evidence of cases against her. ACS told the FCA that based on this history, ACS would be recommending that no more NYC foster CHN be placed in the FM's home. ACS documentation reflected that an Article Ten Petition was filed against the FM on 12/7/04 as her son sexually abused her daughter and the FM did nothing to protect the children. The FM's son was placed in kinship FC with his grandmother and the other children seemed to have been released to the FM with supervision. On 12/9/04, an OP was issued directing her son to have no contact with his siblings. On 4/6/06, an Adjournment in Contemplation of Dismissal (ACD) was issued with 10 months of ACS supervision. The family complied with the family court's orders and supervision ended on 2/7/07.

The FCA informed ACS that FM was licensed for medically fragile CHN, and provided a list of credentials and certifications. ACS inquired why the FCA placed the SC in the FM's home since he was under the age of 1 year, as they noted she was only licensed to board CHN ages 1-21 years. The FCA could not provide an explanation other than stating the CONNECTIONS system did not permit the agency to enter, “0-21 years.” The FCA said the FM had been providing FC services for many years, and she had previously taken infants for services in her home. Upon this review, NYCRO discovered the FM was only authorized to care for 1 foster CH at a time.

ACS Sub the allegations of DOA/Fatality and IG of the SC by the FM. The SC was medically fragile and the FM did not provide the SC with a minimum degree of care when she put him to sleep in an unsafe manner. The FM was trained in safe sleep practices, though she placed him to sleep in a car seat despite having a crib in her home. Additionally, the FM later placed the SC in an unsafe sleeping position in the crib prior to discovering him unresponsive. ACS did not adequately document the basis for substantiating the allegation of IG against the FM regarding the SC in the Investigation Conclusion Narrative.

ACS Unsub the allegation of DOA/Fatality by the parents on the basis that the SC was not in the parent's care at the time of his death. He was hospitalized for a period of time and released with no complications. The SC died while in the care of the FM and there was no credible evidence that the parents' actions or inactions contributed to his death.

ACS Sub the allegations of M/FTTH and IG against the parents based on evidence that the SC was admitted to the hospital as a result of malnourishment and weight loss and diagnosed with M/FTTH. The Dr. confirmed the SC was underweight and dehydrated, and the parent said the SC had not eaten and had been constipated for several days. Another Dr. told ACS that the SC presented as near death on 2/11/17 and was 20% smaller than when he was born. The Dr. said it seemed that the SC was not being fed properly. An assessment was made by ACS that due to the neglect of the SC, the SS's physical, mental, or emotional condition was in imminent danger of being impaired because of the parents' failure to exercise a minimum degree of care. Thus, ACS appropriately added and Sub the allegation of IG against the parents regarding the SS.

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:
NA

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Supervisor Review
Summary:	During the 3/7/17 investigation, ACS did not address the allegation of IG in the Investigation

	Conclusion Narrative regarding the SC. The supervisor approved the determination although the allegation of IG was not addressed.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/07/2017 **Time of Death:** 01:25 PM

Time of fatal incident, if different than time of death: 12:00 PM

County where fatality incident occurred: Queens
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
Adults: 0

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	Foster Parent	Alleged Perpetrator	Female	68 Year(s)
Deceased Child's Household	Other - foster parent's child	No Role	Female	15 Year(s)
Deceased Child's Household	Other - foster parent's child	No Role	Female	29 Year(s)
Deceased Child's Household	Other - foster child	No Role	Female	18 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)

Other Household 1	Father	Alleged Perpetrator	Male	23 Year(s)
Other Household 1	Mother	Alleged Perpetrator	Female	21 Year(s)

LDSS Response

ACS began investigating the suspicious death of the SC within 24 hours of the SCR report. LE investigated as well, though informed ACS early in the investigation that no arrests were made nor charges pending based on preliminary findings from medical staff.

As it was alleged the SC died in the care of the FM, ACS interviewed the FM and persons in her home. ACS learned the FM, her adult daughter, her 15-year-old CH, 18-year-old foster child, and the SS were in the home at the time of the fatality. ACS assessed the safety of the minor CHN under FM's care within 24 hours. As a safety precaution, the SS was moved to another foster home. The 18-year-old foster CH was found not to be in immediate or impending danger of serious harm given the apparent nature of the SC's death, thus it was determined it was not in her best interest to relocate foster homes. On 3/8/17, the 18-year-old foster child was interviewed. She said she was home when the children arrived and also saw them in their room the next day. The FM told her that it was time to go to school so she left. She said she felt safe in the foster home and she liked the foster home. The FM's CH was also found to be safe remaining in the home. The SS was seen at the CAC on 3/9/17 and medically examined. No concerns were found. The SM and SF stated they would not participate in interviews per the advice of their attorney, but were willing to discuss information about the SS. A CSC was held on 3/16/19 to discuss the SS's continued safety.

ACS learned the FM was the last person to see the SC alive. Prior to her discovery that the SC was unresponsive at approximately 12:00 PM on 3/7/17, she cared for the SC throughout the night beginning at the time of his arrival on 3/6/17, which was sometime between 11:30 PM and 12:00 AM. Both the FM and her CHN reported the 3 of them brought the CHN upstairs. The SM and her adult daughter fed the SC and SS at approximately 1:00AM that night. They were changed, burped, and put to sleep. FM confirmed the SC was put to sleep in a car seat, and the SS was put to sleep in a crib. At about 5:00 AM, the SC awoke and the FM fed him and changed his diaper. He was put back to sleep in the car seat. At approximately 9:00 AM, the SS awoke and the FM brought him downstairs. She transported the SC into the crib, which reportedly only contained a sheet. Initially she placed him on his back, but then switched him to his stomach. Around 12:00 PM, FM checked on the SC and found him unresponsive. FM spoke with the FCA who called her at that time, and FM called 911 as instructed. EMS responded, though the SC was unresponsive and not breathing at the time of their arrival.

The attending Dr. who treated the SC at the hospital reported the SC presented without a pulse. The Dr. said tests could not be completed because the SC's blood was clotted, which he reported to signify the SC was deceased approximately 1 hour; however, the Dr. noted follow up with the ME was needed to confirm this. The SC did not have any obvious marks or bruises. Though the information was not received by the time ACS closed the case, NYCRO was forwarded a copy of the final autopsy report, learning the cause of death was positional asphyxia. The manner was accidental, and it was noted that the SC was prone and in the face-down position on a folded blanket in a crib. It also noted a contributing cause to be premature birth and recent viral respiratory infection.

ACS spoke with the FCA regarding the appropriateness of the SC and SS's placement with the FM, and was forthcoming about their concerns. ACS determined no other CHN would be placed with the FM.

On 3/10/17, a visit was conducted to the SM's home. The SF did not attend and he informed ACS he was instructed by his attorney not to speak with ACS. The SM spoke about how she experienced the death of the SC. The SM denied she used drugs. At other points during the investigation, attempts were made to engage the parents though the parents refused per the advice from their attorney.

ACS spoke with the CP who had no concerns regarding the FM or the 18-year-old foster child who was under FM's care. ACS also communicated with PPRS staff who had worked with the family beginning on 11/17/16. The staff noted safe sleep was discussed with the SM and SF following the SC's birth. They also discussed services that were provided to the family during that time. The FCA informed ACS that they offered bereavement counseling to the parents, but the parents chose to use their current therapists assist them through this process. The SM was also not receptive to funeral arrangements.

ACS checked in on the SS. He was observed at the home of his new foster parent. He was observed to be healthy, and under the care of the new foster parent; he was appropriately supervised.

Though there was an instance of inadequately documenting rationale for one of the allegations in the Investigation Conclusion Narrative, ACS appropriately determined the report and each respective allegation against the subjects. Services continued with the family, as necessary.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to previously approved protocols for joint investigations.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039961 - Deceased Child, Male, 2 Mons	039986 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
039961 - Deceased Child, Male, 2 Mons	039986 - Mother, Female, 21 Year(s)	Malnutrition / Failure to Thrive	Substantiated
039961 - Deceased Child, Male, 2 Mons	039987 - Father, Male, 23 Year(s)	Malnutrition / Failure to Thrive	Substantiated
039961 - Deceased Child, Male, 2 Mons	039987 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated
039961 - Deceased Child, Male, 2 Mons	039986 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
039961 - Deceased Child, Male, 2 Mons	039981 - Foster Parent, Female, 68 Year(s)	Inadequate Guardianship	Substantiated
039961 - Deceased Child, Male, 2 Mons	039981 - Foster Parent, Female, 68 Year(s)	DOA / Fatality	Substantiated
039961 - Deceased Child, Male, 2	039987 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated

Mons			
039985 - Sibling, Male, 1 Year(s)	039987 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated
039985 - Sibling, Male, 1 Year(s)	039986 - Mother, Female, 21 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?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
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 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 SC died while in the care of the FM. The SS was re-placed into a different foster home. The SC and SS were remanded on 2/23/17. Both CHN were in the foster home less than 24-hours when the incident occurred.				

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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 FCA said the SF went to one parenting class and the SM was active in parenting. The SM was consistent with therapy and parenting classes that included a DV component. The 4/6/17 safety assessment for the 3/7/17 report reflected that the SF had been reported by mandated sources as being aggressive and controlling, although the parents have denied DV. The SF discharged himself from a Samaritan Village organization program and the director told him he needed bereavement 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? Yes
Explain:
The SS was re-placed into a different foster home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SF was required to receive anger management which was being addressed in individual therapy. The social worker from parents lawyer's office referred the family for services and parenting skills class.

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?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
Was the child acutely ill during the two weeks before death?	Yes

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)
02/11/2017	Deceased Child, Male, 1 Months	Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Indicated	Yes
	Deceased Child, Male, 1 Months	Mother, Female, 21 Years	Malnutrition / Failure to Thrive	Indicated	
	Deceased Child, Male, 1 Months	Father, Male, 23 Years	Inadequate Food / Clothing / Shelter	Indicated	
	Deceased Child, Male, 1 Months	Father, Male, 23 Years	Malnutrition / Failure to Thrive	Indicated	

Report Summary:
The 2/11/17 report alleged that the SC was extremely malnourished and had been losing weight as a result. The SC was born premature and weighed 5.5 pounds. As of 2/11/17, the SC weighed 4 pounds. The parents failed to feed the SC for an unknown amount of time. The SC had blood in his stool and constipation, and was brought for evaluation several days prior to 2/11/17. The SC required placement in a medical facility. The SS had an unknown role.

Determination: Indicated | **Date of Determination:** 04/27/2017

Basis for Determination:
The parents failed to provide a minimum degree of care to the CHN. There was a strong odor coming from the CHN's body as they were not being washed and they wore unclean clothes. The SC was severely malnourished and failure to thrive. The SC was severely malnourished and did not receive adequate food and medical care. The SC also required a medical treatment for his illness.

OCFS Review Results:
On 2/11/17, the parents sought medical attention because the parents reported that the SC had not eaten and was constipated for several days. The SC was determined to be severely underweight and at risk of death due to malnutrition/failure to thrive.

On 2/11/17, the SM was interviewed and information was documented. However, the allegations of the report were not addressed during the interview.

On 2/13/17, the attending Dr. said the SC was near death; he was 20% smaller than when he was born. It seemed he was not being fed properly. The SC had severe malnutrition and severe failure to thrive. Since he had been in the hospital he had gained weight.

On 2/22/17, an Article Ten petition was filed. On 2/23/17, the 1027 hearing occurred and the CHN were remanded to ACS. The SS was transported to pre-placement at ACS and the SC remained in the hospital for treatment.

On 2/27/17, the SC was discharged from the hospital and transferred to pre-placement at ACS.

The SC died on 3/7/17 while in the care of the FP.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
The 4/25/17 safety assessment was inadequate as it included comments that did not support the selected safety factor. Regarding the comment, "On 2/22/17, the father tested positive for marijuana," ACS did not include justification to determine whether the SF's drug us had a negative impact on his ability to provide care of the CHN.

Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(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.

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The Seven Day safety assessment was inadequate as ACS did not identify the safety factor that placed the CHN in immediate danger.

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

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:
Timely/Adequate Case Recording/Progress Notes

Summary:
Investigation Progress Notes were not entered contemporaneously as an event occurred on 2/13/17, but was not entered until 4/13/17.

Legal Reference:
18 NYCRR 428.5(a) and (c)

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/23/2016	Sibling, Male, 4 Months	Mother, Female, 21 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 4 Months	Father, Male, 22 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 6/23/16 report alleged the SF had severe mental health issues. The report also alleged the SF was aggressive toward other adults and the SM, and had physical DV issues in his residence with the SS being on site. The SF refused treatment for illness thus placing the SS at risk of harm. The SF had thrown the SS up in the air which could have caused potential harm to the SS. The SM failed to intervene.

Determination: Indicated **Date of Determination:** 08/22/2016

Basis for Determination:
ACS substantiated the allegation of IG of the SS by the SF on the basis that the SF had an illness that was not addressed and as a result he became very aggressive with individuals. The SF was inappropriate with the SS as he cursed at the child as well. The parents denied DV; however, the SF was aggressive with other individuals and it was suspected that he was aggressive with the SM as well.

ACS unsubstantiated the allegation of IG of the SS by the SM as the SM was compliant with services and provided care of the SS in an appropriate manner. The SM continued to deny DV occurred between her and the SF.

OCFS Review Results:
On 6/23/16, the SM denied there was DV in her relationship with the SF. The SM denied the SF threw the SS up in the air.

During the investigation, the parents agreed to receive Family Preservation Program (FPP) services. The SM would keep her clinical health treatment therapy appointments on 7/14/16 and 8/22/16. Safe sleep practices were discussed and the SM agreed to keep the unit clean. The service plan included parenting skills training and EI screening for the SS. The SF would start parenting classes on 8/17/16. He completed an intake at a medical facility and tested negative for drugs. He was to be referred to an accountability program.

The documentation reflected there were Investigation Progress Notes that were not entered contemporaneously. The events that occurred on 6/24/16, 7/12/16 and 7/13/16 were not entered until 8/22/16.

ACS did not address the discrepancy between the Seven Day safety assessment dated 6/30/16 and the Five Day Supervisory review that was conducted on 6/30/16. The review reflected that the SS was in danger in the care of the parents. However, the safety assessment document did not identify the safety factor that placed the SS in immediate danger. The case record reflected that the SM was on probation for stabbing her aunt in 2014. The Specialist attempted to contact the SM's assigned probation official; however, there was not follow up to obtain information about the case circumstance.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
The documentation reflected that progress notes were not entered contemporaneously as there were events that occurred on 7/12/16 and 7/13/16, but were not entered until 8/22/16.

Legal Reference:

18 NYCRR 428.5(a) and (c)

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:

Timely/Adequate Seven Day Assessment

Summary:

ACS did not address the discrepancy between the Seven Day safety assessment of 6/30/16 and the Five Day Supervisory review that was conducted on 6/30/16. The review reflected that the SS was in danger in the care of the parents; however, ACS did not identify the safety factor that placed the CH in immediate danger.

Legal Reference:

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

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 reflected that the SM had been on probation for stabbing her aunt in 2014. The Specialist contacted probation office in an effort obtain information about the status of the case. A message was left requesting contact. However, ACS did not make diligent efforts to determine the status of the SM's probation issue. The documentation of the 6/23/16 investigation did not reflect the Specialist interviewed the SM's therapist nor did they interview staff associated with the SF's medical facility.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/25/2016	Sibling, Male, 7 Days	Mother, Female, 21 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 7 Days	Father, Male, 22 Years	Inadequate Guardianship	Unfounded	

Report Summary:

The 2/25/16 report alleged that the parents had mental health issues and they adamantly refused treatment. The report also alleged that this placed the SS (1 week old), who was born six weeks premature, at risk of harm.

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

Basis for Determination:

ACS unsubstantiated the allegation of IG on the basis that the parents were assessed by ACS on several occasions and their behaviors remained consistent. The parents were previously diagnosed and prescribed medication, but for the past few years neither of them received treatment or were prescribed medication. ACS attempted to utilize the services of mobile crisis, but the request was denied as neither parent were decompensating or experiencing a "mental crisis." The

infant seemed healthy and had been reaching his milestones. The parents meet all of his needs and there had been no identified safety concerns.

OCFS Review Results:

The SM said 2014 was the last time she engaged in therapy sessions or used medication. She stopped therapy and the medication due to her unstable living situation. The SF denied having a clinical health history.The SF said he was in FC and hospitalized several times; his last was in 2012.

ACS offered services to the family which included clinical health evaluation/therapy and parenting skills. There was a child care provider on site that had been assisting and showing them how to care for the SS.

Investigation revealed the parents had extensive mental health issues, they had been homeless, and the SF's statement that he was a gangster was not true. The SM encouraged the SF's delusional behavior and sometimes referred to the SF as a gangster. The SF refused treatment and had been hospitalized several times for treatment of his condition. He was also known to carry a knife and had violent tendencies. The SM had a violent history and she physically assaulted a family member in the past. The SM had financial resources and an
appointed trustee who could provide information on the family. The SW discussed possible protective removal of the SS from the parents' care because of the concerns and fear that the parents could harm the SS.

The SM had refused a referral for mental health evaluation and the SF had refused offers for assistance.

The 3/2/16 and 4/6/16 safety assessments were inadequate as the associated comments did not support the safety factor that stated, "both parents have mental health diagnosis and not currently in any treatment or taking prescribed medication." A progress note dated 4/11/16 reflected the SS appeared healthy and had been reaching his milestones, the parents met the needs of the SS, ACS staff observed more than adequate provisions for the SS, and there were no safety concerns.

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 3/2/16 safety assessment was inadequate as ACS selected the safety factor that stated both parents had mental health and were not in treatment or taking any prescribed medication. However, ACS did not obtain information to verify the parents' capability to provide care of the SS.

Legal Reference:

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

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:

Predetermination/Assessment of Current Safety and Risk

Summary:

The 4/6/16 safety assessment was inadequate because ACS selected the safety factor that stated the parents had mental health and were not in treatment or were taking medication. However, in the Investigation Progress Note dated 3/8/16, ACS included information that was obtained from Mobil Crisis confirming that the parents had willingly accepted therapeutic services and had not exhibited bizarre behavior or de-compensation. Further, an ACS progress note dated 4/11/16 reflected the SS appeared healthy and had been reaching his milestones, the parents met the needs of the SS, ACS staff observed more than adequate provisions for the SS, and there were no safety concerns.

Legal Reference:

18 NYCRR 432.1(aa)

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:

Pre-Determination/Supervisor Review

Summary:

The supervisor approved the 3/2/16 and 4/6/16 safety assessments although the associated comments did not match the information that was included in the Investigation Progress Notes.

Legal Reference:

18 NYCRR 432.2(b)(3)(v)

Action:

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

[redacted]

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

The parents were not known to the SCR or ACS as subjects more than three years prior to the fatality.

According to the ACS case record, the FM was known to the SCR and ACS in several reports between 8/13/92 and 2/5/07. The reports dated 8/13/92, 11/9/92 (two reports), an unlisted date in 1997, 12/21/00, 12/2/04 and 12/8/04 (two reports) were UNF. An Article Ten Neglect petition was filed, naming the FM as the respondent, and alleging her male CH sexually abused her female CH and the FM did nothing to protect the children. The male CH was placed in kinship foster care with his grandmother and the other CHN were released to the FM with COS. Their supervision ended in 2007. The 2004 report was initially IND against the FM, but the case was overturned due to an appeal she filed. A report was registered on 2/2/05; the report was UNF. The ACS case record included only limited information regarding the details of the reports that were registered between 1992 and 2007; therefore, NYCRO did not assess the quality of these investigations.

The FM was known as a subject in five reports between 6/9/10 to 6/27/13. Two of the investigations reflected her role was listed as a parent, and in four of the investigations her role was listed as a foster parent. The allegation of the 6/9/10 report was EdN of a 15-year-old male CH (now adult) by the FM. On 8/5/10, ACS unfounded the 6/9/10 report.

The allegations of the 12/17/10 report were IG and XCP of a female foster CH, who was then 14 years old, by the FM. On 2/11/11, the report was UNF.

There were two Court Ordered Investigations registered on 3/22/11. The allegation of the first report was Other of a 16-year-old CH (now an adult) by the mother, which was UNF on 5/4/11. The allegation of the second report was Other of a female foster CH, who was then 17 years old, by the FM and FM's son, which was UNF on 5/5/11.

The allegations of the 6/27/13 report were IG and LMC of two foster CHN, who were then 6 months old and 1 year old, by the FM. On 8/1/13, ACS UNF the report.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The FASP due date was 4/5/17, but it was not completed until 5/11/17.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The Catholic Charities Neighborhood Services progress notes reflected that there were events that occurred on 8/8/16, 8/11/16, and 8/12/16 but were not entered until 9/29/16.
Legal Reference:	18 NYCRR 428.5(a) and (c)
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:	Timeliness of completion of FASP
Summary:	The FASP due date was 4/5/17, but it was not completed until 5/11/17.
Legal Reference:	18 NYCRR 428.3(f)(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:	Adequacy of case recording
Summary:	The documentation of the 2/9/17 visit did not clarify whether the CP of Catholic Charities Neighborhood Services asked the parents to conduct a full body check of the SC as two days later the SC needed immediate medical care at the hospital to address serious illness.
Legal Reference:	18 NYCRR 428.5(c)
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.

Preventive Services History

During the 2/25/16 investigation, ACS opened the Family Service Stage of the case on 3/9/16 as the parents had clinical health issues and refused treatment. ACS assessed that the parents placed the then 1-week-old infant (SS) at risk of harm. ACS held a conference with the parents who agreed to participate in services to address health, therapeutic and parenting needs. The family was referred to the Church Avenue Merchants Block Association (CAMBA) agency for PPRS. The parents signed an agreement for PPRS services on 3/25/16.

The 6/7/16 FASP reflected the parents participated in the Safety module in which they completed five sessions. The parents continued to engage in CAMBA's services and attempted to complete the Safe Care program. The SM engaged in clinical health services by attending appointments. She received services as well as counseling from a community based organization (CBO). The SF struggled with becoming engaged in services. He was scheduled to attend an appointment with the CBO but he did not attend and said he forgot about it. It was brought to CAMBA's attention that the SF exhibited out of control behavior and became more aggressive with the SM, residents, and staff members in the shelter. A referral to the mobile crisis team was made but he refused their assistance.

During the 6/23/16 investigation, two separate conferences occurred at ACS. The family accepted FPP. The CP referred the family to a Family Treatment Rehabilitation (FTR) program. On 7/21/16, the case was referred by CAMBA to the Catholic Charities (CC) Neighborhood Services. According to the referral information, a conference occurred on 7/12/16 as a result of the parents' noncompliance with therapeutic services. The SF was aggressive to shelter staff prompting a clinical health warrant. The SF did not follow through with hospital recommendations. The SF said he voluntarily stopped using cocaine and marijuana three months and six weeks, respectively, prior to July 2016.

On 1/4/17, ACS received an Additional Information (AI) from the SCR. According to the AI, 1/4/17 at about 12:25 AM, there was a loud noise that came from the family’s apartment. The shelter staff investigated and found the SF used profanity and threatened the staff for intervening. The children and the SM were present when this occurred. LE was contacted, the parents were interviewed, but no arrests were made as there were conflicting versions in the accounts. ACS visited the home on 1/4/17. The SF informed ACS that he and the shelter staff became involved in a verbal altercation after the staff knocked on his unit door for no reason demanding to see the children and the SM. The SF said he refused to allow the staff to enter the unit and the situation escalated. During the ACS visit, the SF displayed aggressive behavior.

On 1/25/17, a child safety conference (CSC) occurred. As a result of the CSC, the service plan included: the SM to coordinate with her children’s Dr. to assess the needs for EI, complete assessment for DV and attend DV counseling. The SM would receive a comprehensive mental health evaluation, continue to cooperate with shelter guidelines, and continue receiving services with the CC agency. Recommendations were also made for the SF.

The 4/5/17 FASP reflected the SM had been attending counseling with the CC agency once a week. The SF also attended anger management sessions with CC. The parents attended a parenting skills program at a family resource center. The SF had chosen to attend another drug treatment program on 4/19/17.

Foster Care at the Time of the Fatality

The deceased child(ren) were in foster care at the time of the fatality? Yes
Date deceased child(ren) was placed in care: 03/06/2017
Date of placement with most recent caregiver? 03/06/2017
How did the child(ren) enter placement? Court Order

Review of Foster Care When Child was in Foster Care at the time of the Fatality

	Yes	No	N/A	Unable to Determine
Does the case record document that sufficient steps were taken to safeguard this child's safety while in this placement?	☐	☐	☐	☒
Did the placement comply with the appropriateness of placement standards?	☐	☒	☐	☐
Was the most recent placement stable?	☒	☐	☐	☐
Did the agency comply with sibling placement standards?	☒	☐	☐	☐
Was the child AWOL at the time of death?	☐	☒	☐	☐

Visitation

	Yes	No	N/A	Unable to Determine
Was the visitation plan appropriate for the child?	☐	☐	☒	☐
Was visitation facilitated in accordance with the regulations?	☐	☐	☒	☐
Was there supervision of visits as required?	☐	☐	☒	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource made with required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource in the parent/relative/discharge resource's home made with required frequency?	☒	☐	☐	☐
Were all of the casework contact requirements for contacts with the caretakers made, including requirements for contact at the child's placement location?	☒	☐	☐	☐

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the agency provide the foster parents with required information regarding the child's health, handicaps, and behavioral issues?	☐	☒	☐	☐
Did the provider comply with discipline standards?	☒	☐	☐	☐
Were the foster parents receiving enhanced levels of foster care payments because of child need?	☒	☐	☐	☐

If yes, was foster parent provided a training program approved by OCFS that prepared the foster parent with appropriate knowledge and skills to meet the needs of the child?	☒	☐	☐	☐
Was the certification/approval for the placement current?	☒	☐	☐	☐
Was a Criminal History check conducted? **Date:**	☐	☐	☐	☒
Was a check completed through the State Central Register? **Date:** 01/22/2009	☒	☐	☐	☐
Was a check completed through the Staff Exclusion List? **Date:**	☐	☐	☒	☐
Additional information, if necessary: NA				

Required Action(s)

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

Issue:	Adequacy of monitoring child/family while in foster care
Summary:	Despite verification of information that reflected the two CHN had very recent illnesses, the ACS Children's Center cleared the children for placement on 3/6/17.
Legal Reference:	18 NYCRR 441.21
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:	Appropriateness and adequacy of child's foster care placement
Summary:	The foster care placement of the two CHN was inappropriate. At the time the SC and SS were placed with the FM on 3/6/17, the FM was authorized to provide care of one male child between the ages of 0 years and 0 months and 0 years and 0 months and/or one female between the ages of 18 years 0 months and 21 years 0 months with a maximum capacity of 1 CH.
Legal Reference:	18 NYCRR 430.11(c) or (d)
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.

Foster Care Placement History

ACS filed an Article Ten Abuse petition in Family Court on behalf of the CHN on 2/22/17. The parents were named as the respondents. The SC was hospitalized from 2/11/17 through 2/27/17. He was discharged to the ACC where he met with SS. The SS resided at the ACC from 2/23/17 to 3/6/17.

The ACC Nursery Log Book Entries reflected the SC arrived as a new intake on 2/27/17 at 7:26 PM. The log notes

reflected that the SS had arrived on 2/23/17. On 3/1/17, at 4:20 PM, the Log Book reflected that the SS returned from the ER. The Log did not reflect when he departed for the ER. On 3/2/17, the SS was monitored for a medical issue. On 3/3/17, at 10:35 PM, the SS went to the hospital; however, the Log entry did not provide the reason for hospital visit. The Log reflected that on 3/5/17, at 2:30 AM, the SC was running out of formula. The nurse permitted the use of another formula for the SC as an alternative, on a temporary basis. On 3/6/17, at 10:30 PM, both children left for their placement.

ACS medical notes reflected that on 3/1/17 and 3/6/17, the SC had nasal congestion. On 3/1/17, the SC returned from an appointment at the Mt. Sinai Hospital. At 10:15 PM on 3/6/17, the SC was cleared for placement. The medical notes reflected that on 3/1/17, the SS had labored breathing. He was transported to the hospital ER. On 3/3/17, the attending Dr. called ACC regarding the SS. The Dr. said the SS seemed to have a medical condition that needed to run its course.

The SS returned to the Children's Center from a Dr. appointment on 3/6/17 at 1:30 PM. The SS had a follow-up appointment and was prescribed medication. At 10:00 PM, the SS had a temperature of 100.8 degrees and medication was administered. The SS was cleared for placement. The medical notes did not reflect that the SS was taken to a Dr. to address concerns pertaining to the temperature of 100.8 degrees and nasal congestion symptoms. The medical notes reflected that, prior to the SC's death, the last time the SS saw a Dr. was on 3/6/17.

The documentation for the SC reflected that his last time at the Dr. was on 3/1/17 during an appointment at Mt. Sinai Hospital pediatrics. The SS was seen the same day at the Bellevue Hospital and according to the Nursery Log Book Entries, the SS went to the hospital on 3/3/17.

On the night of 3/6/17, both CHN were placed with the FM under the supervision of the HeartShare St. Vincent's FCA. Several hours later on 3/7/17, the SC died while in the care of the FM.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒ Family Court ☐ Criminal Court ☐ Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/22/2017	There was not a fact finding	There was not a disposition
Respondent:	039986 Mother Female 21 Year(s)	
Comments:	The documentation reflected that an Article Ten Abuse petition was filed on 2/22/17 in the Queens County Family Court regarding the SC and SS. The parents were named the respondents. The Family Court remanded the children to the care and custody of ACS.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/22/2017	There was not a fact finding	There was not a disposition
Respondent:	039987 Father Male 23 Year(s)	
Comments:	The documentation reflected that an Article Ten Abuse petition was filed on 2/22/17 in the Queens County Family Court regarding the SC and SS. The parents were named the respondents. The Family Court remanded the children to the care and custody of ACS.	

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