Child Fatality Report

Report Identification Number: NY-20-088

Prepared by: New York City Regional Office

Issue Date: Mar 09, 2021

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 09/24/2020
Initial Date OCFS Notified: 09/24/2020

Presenting Information

The initial SCR report alleged, on 9/24/20, at an unknown time, the caregiver found the 3-year-old child unresponsive in his home. It was unknown how long the child had been unresponsive, as the caregiver's account of the incident changed. Initially, the caregiver stated that the child had vomited at approximately 2:00PM and had been unresponsive since 2:30PM. The caregiver later stated that the child was unresponsive since the morning (time unknown). The caregiver was aware that the child was unresponsive and had vomited but failed to obtain immediate medical care for the child. Sometime after 4:00PM, the caregiver drove the child to a hospital, which was 40 minutes away, and passed by multiple hospitals on the way to this specific hospital, further delaying medical treatment for the child. Upon arrival at the hospital, at 5:03 PM, the child was blue, cold to the touch, and had fixed, dilated pupils. The child was unable to be revived and was pronounced dead. The child was otherwise healthy, and the caregiver had no explanation for the child's death. The roles of the mother and the grandmother were unknown.

Additional information provided to the SCR stated on 9/23/20, the mother allowed her daughter 3-year-old daughter to spend the night at the caregiver's home. The caregiver is the grandfather to another 4-year-old child who was best friends with the 3-year-old subject child. The two children were spending the night together in the caregiver's care and at his home in the Bronx. On 9/24/20 at approximately 5:00PM, the caregiver walked into the hospital with the 3-year-old child who was dead on arrival. The caregiver was questioned by police and his answers kept changing and were inconsistent. He was arrested, unknown what charges.

Executive Summary

This fatality report concerns the death of a three-year-old female subject child that occurred on 9/24/20. A report was made to the SCR on that same date with allegations of DOA/Fatality, Lack of Medical Care, and Inadequate Guardianship against the child's caregiver. The Administration for Children's Services (ACS) received the report and investigated the child's death. An autopsy was completed; however, the final report remained pending at the time of this writing.

At the time of the child's death, she resided with her mother, maternal aunt, and grandparents in Brooklyn; however, she was on a sleepover with a friend in an unrelated individual's home. For the purposes of this report, the individual will be referred to as the caregiver. The child's father resided elsewhere and had some contact with the child.

The investigation revealed that on 9/23/20, the child's mother allowed the child to spend the night with the caregiver and return the following morning 9/24/20, so that she could go to school. The child's four-year-old best friend was also participating in the sleepover. The caregiver left with the girls at 8:00PM. The documentation did not reflect if the mother attempted to contact the child during the time she was away from home. At about 10:00 AM on 9/24/20, the mother went to the four-year-old child's home to pick up the child, but learned there was a change in plans, as the children would be returning later in the day. At approximately 5:30 PM on 9/24/20, the mother received a call from the hospital indicating the child was undergoing resuscitative efforts. The mother went to the hospital in Queens and learned the child had died.

The caregiver expressed being hurt and affected by the death of the child, in addition to the innuendos circulating regarding his involvement in the child's death. The caregiver said he was arrested and remained in jail from until 9/26/20. He explained that he was released and must return for court appearances. He denied hurting the child. The caregiver said while at his home, the children and he did not observe any signs that either was sick. However, the three-year-old had a runny nose. Later he was told of the child's diagnosis.

The caregiver said on the day in question, the four-year-old child told him the three-year-old child was asleep and he took the child to the hospital. He explained he chose the hospital in Queens because he felt the child would receive better care. The caregiver said he did not think to take the child to a closer hospital. The caregiver refused to answer any questions regarding drug or alcohol use on the night the children were in his house and ended the call. The caregiver refused all services.

On 11/23/20, ACS substantiated the allegations of DOA/ Fatality, Inadequate Guardianship, and Lack of Medical Care of the three-year-old child by the caregiver whom they deemed a person legally responsible on the basis that credible evidence existed showing that the caregiver failed to call 911 for assistance once the child was found unresponsive. In addition, the caregiver took the child to hospital in Queens which was forty minutes away although there were hospitals in close proximity to his residence in the Bronx. ACS surmised this delayed any medical attention the child could have received. The child died.

From the time the investigation began to the time of its closure, ACS interviewed family members and pertinent collateral sources. Law enforcement reported the caregiver was arrested and charges of Endangering the Welfare of a Child and Acting in a Manner Injurious to a Child under 17 were pending. The caregiver was later released on his own recognizance and would need to appear for subsequent court dates. ACS provided the family with appropriate services referrals in response to the death of the child, including bereavement counseling.

The report was indicated and the services case which was previously opened for Court Ordered Services continued.

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:
The casework activity was commensurate with case circumstances. Sufficient information gathered to make determination for all allegations and the determination was appropriate.

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

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

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/24/2020 **Time of Death:** 05:36 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 001
Adults: 000

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	15 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	39 Year(s)
Deceased Child's Household	Mother	No Role	Female	20 Year(s)
Other Household 1	Unrelated Home Member	Alleged Perpetrator	Male	59 Year(s)

LDSS Response

On 9/24/20, ACS initiated the investigation with the convening of a Heightened Oversight Protocol (HOP) conference, given the age of the child and the allegations of the report. ACS's Investigative Consultants (ICs) provided pertinent details from the caregiver's criminal history and provided directives to guide the investigation.

On 9/24/20, the Specialist interviewed hospital personnel and learned the caregiver appeared at the ER and told the triage nurse there was a child who was unresponsive, in his car. The triage nurse ran to the car and escorted the child into the ER. Attempts were made to revive the child who started bleeding from her nose. According to the hospital staff person, the caregiver said the child had an episode of vomiting at approximately 2:00 PM. At 5:36 PM, the child was declared dead. Test results also showed child was positive for COVID-19. Hospital personnel stated the caregiver traveled from the Bronx to hospital in Queens, and it was unknown why he failed to contact 911 or to escort the child to a hospital that was closer. Hospital staff further stated there was another child with the caregiver at the time he arrived at the hospital.

The Specialist contacted law enforcement on 9/24/20 and again on 9/25/20, and learned the mother allowed the child to spend the night with her best friend. The children were under the supervision of the caregiver at his home in the Bronx. The detectives stated the caregiver had dated the grandmother of the 4-year-old child who was with the caregiver when he brought the 3-year-old child to the hospital. The detectives said the cause of death was pending, and that an autopsy would be performed. The caregiver was arrested and would be charged with Child Endangerment and Acting in a Manner Injurious to a Child Under 17 as they had received video footage showing the caregiver carrying the child's lifeless body from his home, which is a Single Resident Occupancy by himself, placing the child in his car but not arriving to Cohen Hospital until 3 hours later.

On the same date, the Specialist interviewed the mother who explained she had known the caregiver for many years as he was the grandfather of her child's best friend. She also stated this was not the first time the child had been on a sleepover in the caregiver's home, but this was the first time the child went on a sleep over in the Bronx. The mother stated when the child and her friend begged her to allow the child to go to the home of the caregiver for a sleep over, she gave in and allowed it. She stated she received a phone call from the hospital at approximately 5:30 PM on 9/24/20 stating they were attempting to revive the child.She stated she quickly took a cab to the hospital. The mother stated she did not understand the reason caregiver took the child to the hospital in Queens.

The mother said she had a chance to speak with the 4-year-old child who told her they (both children) went to sleep, woke up, and ate. They began to play and the 3-year-old child "dropped to the ground". The mother said her child was seen by her pediatrician for a checkup the first week of September and there were no concerns noted by the doctor. The mother stated when she informed the child's father about the child's death, he began to cry.

The mother stated the child was well and lively; there was nothing wrong with the child, except for a cough on 9/23/20. She stated when she placed her hand on the child's forehead, the did not feel feverish.
The Specialist also interviewed the child's maternal aunt. She stated the last time she saw her niece was yesterday. She stated during that time, the child was fine, full of life and very playful. She stated she had no issues with the care the niece had received. She stated she did not know caregiver well, but was cordial to him. ACS assessed that the basic needs were being met. There was sufficient food in the home and the maternal aunt's sleeping arrangements were adequate. The maternal aunt also had her own desk and work area for remote learning and clothes suitable for the weather.

The MGM was also interviewed. She explained she knew the caregiver and had no concerns about him. She too described the child as very energetic and full of life. She stated the child was happy go lucky child. She stated the child has always been healthy and there were no issues with her health.

The Specialist also interviewed the child's maternal great grandfather (MGGF) who stated that he picked up the child from

day care on 9/22/20 at about 4:30 PM and that he last saw the child on the morning of 9/23/20 at about 8:00 AM. The MGGF stated that he observed the child in the home running around, and being playful in the apartment. He said the child was not sick, coughing, or in distress.

On 9/25/20, the ME reported that the autopsy was in process but has not been completed. The preliminary findings were undetermined. The child had no internal or external injuries, but there were gross findings of pneumonia in the lungs. The ME confirmed these findings were consistent with the CVOID-19 diagnosis. The ME also stated it would take several weeks for the final results.

On 9/25/20, the playmate of the subject child was interviewed. The child provided a general idea of the activities for the time they spent with the care giver and added the 3-year-old child had spicy food, they ate "noodles", and after playing they went to bed. The child said when they were in the bed, the 3-year-old child closed her eyes. She said she tried waking the 3-year-old, but the child did not wake up. Afterward "Pop Pop" (caregiver) took the child to the hospital.

The mother of the 4-year-old child said the children were familiar with the caregiver, and on 9/23/20 both girls "begged" for the sleepover when they learned the 4-year old child's mother would be going to the caregiver's home. The mother of the 4-year-old child said the adults discussed the plan that the children to spend the night with the caregiver and return the following morning (9-24-20), so they could go to school. The mother of the 4-year-old said the caregiver left with the girls at 8:00PM. She did not hear from the caregiver that night, so she assumed all was well with the girls. She said the caregiver called her in the morning stating that he was going to take the children to get something to eat so they decided that the children would return home later that day and not attend school. The 4-year-old child's mother confirmed that the mother of the 3-year-old child came to her home around 10:00AM to pick up the child but returned home when she heard the plans had changed. The mother of the 4-year-old child said she did not hear from the caregiver again until about 5:00PM when he called to say something had happened to the 3-year-old child and the hospital needed the telephone number for the child's mother. The 4-year-old child's mother stated she believed the caregiver took the child to the hospital in Queens because he was most familiar with that hospital and he believed that hospital provided the best care for children.

On 9/28/20, law enforcement reported the caregiver was released on his own recognizance. The original charges of Acting in Manner Injurious to a Child under 17 and Endangering the Welfare of a Minor were not included.

The Specialist contacted the ACS Family Services Unit (FSU) team on 9/28/20 and learned the last contact with the child had taken place on 9/9/20 at her day care center. At that time, the child appeared happy and she was assessed to be free of any suspicious marks or bruises. The FSU CPS explained that the child was not exhibiting any signs of sickness but recalled that earlier in the summer the family went on a vacation. However, none of the family members exhibited any signs of COVID-19 when they returned.

The FSU team also explained their involvement with the family and noted that during their involvement, the father failed to comply with any services or supervised visits at the agency. The FSU team noted that in March an extension to supervision was granted by the courts. The agency had the discretion to expand visits based on the father's compliance. The father was ordered to engage in Batterer's Accountability and parenting skills training; however, he did not follow up with FSU or services. Regarding the mother, the FSU team explained that PPRS was explored but the mother declined. The FSU Specialist had no knowledge of the caregiver. There were no concerns regarding drug use or mental health. Further there were no concerns regarding the child.

On 9/28/20, the Specialist contacted the child's pediatrician and confirmed the child had been healthy. Her last visit was on July 27, 2020 for a wellness check. The child had no comorbidities, no asthma, or heart problems.
Between 9/28/20 and 11/5/20, the Specialist made several visits to the family's home. No new information was obtained.

On 11/16/20, the death certificate was received. The immediate cause of death was listed as "pending further study."

After repeated attempts, the care giver was interviewed on 11/20/20 via phone. The caregiver expressed being hurt and affected by the death in addition to the innuendos. The caregiver said he was arrested and remained in jail from until 9/26/20. He explained that he was released and must return for court appearances. He denied hurting the child. The caregiver said while at his home, the children and he did not observe any signs that either was sick. However, the 3-year-old had a runny nose. Later he was told of the child's diagnosis.
The caregiver said on the day in question, the 4-year-old child told him the 3-year-old child was sleep and he took the child to the hospital. He explained he chose the hospital in Queens because he felt the child would receive better care. The caregiver said he did not think to take the child to a closer hospital. The caregiver refused to answer any questions regarding drug or alcohol use on the night the children were in his house and ended the call. The caregiver refused all services.

On 11/23/20, ACS substantiated the allegations of DOA/ Fatality, Inadequate Guardianship, and Lack of Medical Care of the 3-year-old child by the caregiver whom they deemed a person legally responsible on the basis that credible evidence existed showing that the caregiver failed to call 911 for assistance once the child was found unresponsive. In addition, the caregiver took the child to hospital in Queens which was 40 minutes away although there were hospitals in close proximity to his residence in the Bronx. ACS surmised this delayed any medical attention the child could have received. The child died. The report was indicated.

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 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
056457 - Deceased Child, Female, 3 Yrs	056461 - Unrelated Home Member, Male, 59 Year(s)	DOA / Fatality	Substantiated
056457 - Deceased Child, Female, 3 Yrs	056461 - Unrelated Home Member, Male, 59 Year(s)	Inadequate Guardianship	Substantiated
056457 - Deceased Child, Female, 3 Yrs	056461 - Unrelated Home Member, Male, 59 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?	☒	☐	☐	☐
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 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: The family was already receiving court ordered services to address the issues related to domestic violence.				

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?	☐	☒	☐	☐
Explain as necessary: There were no safety factors that placed a surviving child in the home in immediate or impending danger of serious harm. Therefore, no removal was necessary.				

Legal Activity Related to the Fatality

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

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Endangering the welfare of a child **Degree:** NA

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
09/25/2020	Unrelated home member who had child in his care.	09/26/2020	Released on his own recognizance
Comments:	The case is pending in court.		

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	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:
The mother's only child died. Domestic violence services were in place prior to the fatality.

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:
Surviving 15-year-old MA was offered grief counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The other family members were offered grief counseling and burial assistance.

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)
11/20/2018	Deceased Child on Report, Female, 1 Years	Father, Male, 26 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
On 11/20/18 the father of the child assaulted the mother in front of the 1-year old child, by choking the mother . The child was not harmed . The father was arrested as a result of the incident. The allegation of the report was Inadequate Guardianship of the one-year-old child by the father.

Report Determination: Indicated **Date of Determination:** 01/18/2019

Basis for Determination:
ACS indicated the report on the basis that credible evidence existed that the parents had a verbal altercation that swiftly became physical. This occurred in the presence of the child who was sitting on the bed. As a result of the father punching, kicking, and dragging the mother, the child was accidentally hit by the mother as the mother was trying to escape. The father was arrested.

OCFS Review Results:
ACS initiated the investigation in a timely manner. Mandated notifications were sent to the parents. ACS made the appropriate collateral contacts and incorporated the information obtained from these collaterals into the assessments of the family's functioning. ACS recorded the correct safety assessment for the child and noted that there was a full stay away order of protection issued on behalf of the mother and child. ACS also offered the mother the appropriate services. The record reflected attempts to reach the father; however he did not make himself available for any interviews. The case remains open for Court Ordered Supervision of the family as ACS filed an Article 10 Petition against the father on 12/18/18 as a result of the acts against the mother in the presence of the child.

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

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

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

Known CPS History Outside of NYS

There is no known CPS history outside of New York state.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 12/18/2018

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐

Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
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?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Preventive Services History

Court ordered services were provided to the family beginning 12/18/2018 as a result of Domestic violence concerns relating to the child's parents. ACS's Family Services Unit (FSU) was monitoring the family. End of Services was scheduled for March 2020; however, due to the father's failure to follow up with services and supervised visits, supervision was extended indefinitely as the case was administratively adjourned due to COVID-19.

In review of FSS stage notes, the last visit with SC was on 9/9/20 at her day care. Throughout FSU's involvement with the family, the FSU CPS assessed SC to be doing well in the care of the mother who reported having no contact with father in almost 2 years. Additionally, day care providers and family support, MGM, and MA reported the mother was doing well with caring for SC and they had no concerns. Further, the mother was supporting her self with full-time employment. The mother refused any services.

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:**
12/18/2018	There was not a fact finding	Order of Supervision
Respondent:	051301 Other	
Comments:	ACS filed the petition against the father due to the acts of violence against the mother in the presence of the child. The court issued a full stay away order against the father and the child was released to the mother with court ordered supervision. Agency supervised visits between the father and the child were to be held with discretion to expand to an approved resource The last court date was 9/16/2020. The case was administratively adjourned due tot he COVID-19 pandemic. All prior orders were continued. The next court date was listed as 12/25/2020.	

Have any Orders of Protection been issued? Yes	
From: 12/18/2018	**To:** Unknown
Explain: According to the agency's case notes, the order of protection remains in place; however, no definitive end date was provided.	

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