Child Fatality Report

Report Identification Number: NY-20-033

Prepared by: New York City Regional Office

Issue Date: Sep 28, 2020

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: 13 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 04/12/2020
Initial Date OCFS Notified: 04/12/2020

Presenting Information

According to the OCFS-7065, the 13-year-old male child died while playing in the train tracks in Westchester County.

Executive Summary

The family had an open preventive services case beginning 7/5/19. ACS opened the services case to provide case management to the family as the BM was overwhelmed with her family responsibilities and she requested support to manage the child's behavior. The family also had an open CPS investigation that began on 3/26/20.

ACS was investigating the 3/26/20 report when the agency received information about the child's death. The investigative findings showed that at approximately 3:00 PM on 4/12/20, the child climbed on top of a vending machine at a train station in Westchester County. The child then touched live electrical wires and was immediately electrocuted. He reportedly sustained burns throughout his body and was pronounced dead.

ACS submitted the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Services Cases. The information regarding the child's death was reported to OCFS under Chapter 485 of the Laws of 2006.

ACS contacted LE and verified the circumstances of the child's death. LE informed ACS that the child's body was at the ME's laboratory. LE said there were no additional details about the child's death. ACS did not obtain official documents to verify the official cause and manner of death and time of death.

The child had two SS who resided with the BM. ACS visited the family and offered referrals for services to address bereavement needs. The BM did not allow ACS to enter her home and she said she did not need services. ACS observed the SS at the doorway of the home.

The Family Services Progress Notes (FSPN) reflected that between 4/17/20 and 7/17/20, the provider agency held frequent face-to-face meetings with the family. According to the FSPN, on 4/17/20, the provider agency obtained information from the ME, who said the child's body was identified due to his dental structure. The ME and provider agency discussed the likelihood of the child harming himself. The agency noted the child did not demonstrate intent to hurt himself or others as the child had expressed his academic plans to graduate from school and pursue a career. The FSPN reflected the ME said there was no evidence of abuse regarding the child's death.

Prior to the termination of services on 7/23/20, the FSPN showed the family received referrals for bereavement and other support services, the BM appropriately managed her grief and she was an advocate for the surviving siblings.

NYCRO had not yet received the ME's report at the time this fatality report was issued.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
N/A

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:
N/A

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: 04/12/2020 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Unknown
Did EMS respond to the scene? Unknown
At time of incident leading to death, had child used alcohol or drugs? Unknown
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? No - Not needed given developmental age or circumstances

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	No Role	Male	13 Year(s)
Deceased Child's Household	Mother	No Role	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)

LDSS Response

Following the child's death, ACS interviewed LE on 4/13/20. According to LE's account, on 4/12/20, the child was playing in the train tracks and stepped on the third rail, and as a result was immediately electrocuted. LE explained that the child sustained extensive burns to the extent the body was unrecognizable. LE informed ACS that the incident occurred in Westchester County, and assigned detectives were dispatched to inform the BM of the incident.

The BM contacted ACS by telephone and discussed the child's death on 4/14/20. During the telephone contact, the BM said a detective informed her the child was electrocuted. The BM said at the time of the incident on 4/12/20, the child was with his friend. She said the child was staying at his friend's home. She informed ACS that she did not have information about the friend.

ACS contacted LE to obtain additional information about the child's death on 4/14/20. During the contact with LE, ACS learned two of the child's friends provided information to LE. Per the information LE received from the friend's accounts, the friends observed the child climb on top of a vending machine close to live volts wire at the train station in Westchester. The friends said they asked the child to climb down before he electrocutes himself. The child reportedly touched the live wire, he was electrocuted, and his body fell to the ground. LE informed ACS that the body was at the ME's laboratory.

ACS addressed the 8-year-old SS's needs and noted he received nursing services during the daytime, and close monitoring by the BM. This SS received prescribed nutrition, he utilized a wheelchair, and he had adequate sleeping arrangement. ACS discussed the medical and educational needs of the 7-year old SS and verified he received therapeutic services in school. ACS provided the BM with referrals for bereavement. The BM did not accept the ACS referrals. The case remained open for PPRS, and the service provider maintained contact with the family. According to the FSPN, the BM received casework counseling and case management that addressed bereavement. The family received community based services.

On 5/22/20, the SCR registered a report that included the allegations of IG, LMC and IG of the child by the BM. ACS investigated the report and unfounded the allegations on the basis of no credible evidence.

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

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The SS were unable to participate in interviews.

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 received PPRS.				

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 was no removal regarding the SS.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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	☐	☐	☐	☐	☐	☒	☐

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 documentation showed the SS received PPRS and in-home health services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
According to the FSPN, the BM received casework counseling that supported her through the grief process.

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? 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? 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)
03/26/2020	Deceased Child, Male, 13 Years	Mother, Female, 36 Years	Childs Drug / Alcohol Use	Unsubstantiated	Yes

Deceased Child, Male, 13 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 13 Years	Mother, Female, 36 Years	Lack of Supervision	Unsubstantiated

Report Summary:
The 3/26/20 report alleged the BM had no control over the 13-year-old male child. The child frequently smoked marijuana. The child left the home and stayed away from the home unsupervised for about four days at a time. He came home, bathed, rested, changed clothing and disappeared at will again. The problem was ongoing. The two SS had unknown roles.

Report Determination: Unfounded | **Date of Determination:** 05/15/2020

Basis for Determination:
ACS unsubstantiated the allegations of the report on the basis of no credible evidence. ACS explained that there was no evidence the BM placed the child at risk of "actual physical harm."

OCFS Review Results:
ACS visited the home, interviewed the BM and child, and observed the two SS on 3/26/20. The BM did not allow ACS to enter the home and ACS interviewed or observed household members in the hallway. The BM said the child left the home without her permission and did not return until a few days later. The BM asked ACS to assist her with her efforts to manage the child's behavior. The child informed ACS that he visited a friend for a period of a few days. ACS noted the child and two SS had no suspicious marks/bruises.

The investigation was open when ACS learned of the child's death. However, ACS did not obtain official documents to verify the time of death, and the cause and manner.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The investigation was open when ACS received notification of the child's death. The documentation did not indicate whether ACS obtained official records to verify the time of death, the official who pronounced the child dead, and the cause and manner.

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)	Allegation Outcome	Compliance Issue(s)
06/10/2019	Deceased Child, Male, 13 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
The 6/10/19 report alleged the BM had no control over her 13-year-old male child. The child left the home late at night and did not return home until the following morning. The BM did not know the child's whereabouts during the time. On 6/10/19, the child returned home with scratches and bruises he sustained from a fight. The BM was overwhelmed since she was the sole caretaker of the child, and the two SS had special needs.

Report Determination: Unfounded | **Date of Determination:** 07/31/2019

Basis for Determination:
ACS unsubstantiated the allegation of IG of child on the basis of no credible evidence. ACS explained that the child was defiant, the family engaged in mental health services, and the BM used adequate discipline and monitored the child's whereabouts.

OCFS Review Results:
ACS visited the home, interviewed the BM and observed the two SS on 6/10/19. The BM said the child left the home without her consent and he threatened her with a knife. She said she was unable to manage his behavior and she asked ACS to place him. ACS noted the SS did not have marks/bruises.

ACS interviewed the child at home on 6/12/19. The child said he left his home to visit friends, he refused to identify the friend, and he denied drug use. He said he sustained the scratches and bruises when he fell from a friend's bike. He said he was involved in a fight while out of the home. ACS provided referral for a health home program, and opened a preventive services case for the family.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/04/2018	Sibling, Male, 7 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 6 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 12 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Adult Sibling, Male, 18 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Adult Sibling, Male, 18 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 12 Years	Adult Sibling, Male, 18 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 9/4/18 report alleged the adult SS had a history of engaging in violence with the BM. The BM was aware of the adult SS's behavior and allowed him to reside intermittently in the home with the child and two SS. On 9/4/18, the adult SS made threats of harm. The incident occurred in the presence of the child and two SS. The adult SS was taken for an evaluation.

Report Determination: Unfounded | **Date of Determination:** 10/19/2018

Basis for Determination:
ACS unsubstantiated the allegation of IG on the basis the BM obtained medical assistance for the adult SS. The adult SS did not have caretaker responsibility for the child and SS and he no longer resided in the home.

OCFS Review Results:
ACS visited the home, interviewed the BM and MGM, observed the child and SS, and obtained information from collateral contacts on 9/4/18. The BM and MGM said that on 9/4/18, the adult SS attempted to harm himself, 911 was contacted for assistance and he was transported to the hospital. ACS noted the child and SS had no visible marks/bruises.

During an interview with ACS, the adult SS said he wanted to harm himself, and he refused to discuss the incident. ACS contacted officials who verified the adult SS relocated out of New York State. The RAP did not reflect the child and adult SS were in the custody of ACS prior to the 9/4/18 report.

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

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

Summary:
ACS completed the Risk Assessment Profile document on 10/18/18. However, the document did not include information to reflect the child was in ACS custody prior to the 9/4/18 investigation.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/23/2018	Deceased Child, Male, 11 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 5 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 4/23/18 report alleged on an unknown date the BM and father of the SS had a physical altercation in the presence of the child and SS. The BM threw a phone at the father, and the phone hit the father resulting in him sustaining an injury to his nose.

Report Determination: Unfounded **Date of Determination:** 06/12/2018

Basis for Determination:
ACS unsubstantiated the allegation of the report on the basis of no credible evidence.

OCFS Review Results:
ACS visited the home on 4/23/18, observed the child and SS, and noted they did not have marks/bruises. ACS interviewed the BM in the school on 4/24/18. The BM said on 3/28/18, she contacted LE after the father pushed her. She said the children were in their bedroom and did not observe the incident. ACS interviewed the child, who said he did not observe DV incidents in the home. The SS were unable to participate in the interview.

The findings showed the BM and father engaged in DV incidents. The father reportedly died on 5/30/18. The family received in-home services and referrals for bereavement.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/12/2017	Sibling, Male, 4 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 5 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Male, 4 Years	Father, Male, 49 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 5 Years	Father, Male, 49 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 10 Years	Father, Male, 49 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 10 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated

Report Summary:
The 4/12/17 report alleged on numerous occasions the father of the SS physically assaulted the BM in the presence of the child and SS. The BM had visible marks from the most recent incident.

Report Determination: Indicated | **Date of Determination:** 07/18/2017

Basis for Determination:
ACS substantiated the allegation of IG of the child by the BM on the basis the child had excessive school absences, and at some point in time his promotion was in doubt.

ACS unsubstantiated the allegation of IG of the SS by the BM and IG of the child and SS by the father on the basis of no credible evidence.

OCFS Review Results:
ACS visited the home on 4/12/17, interviewed the BM, father and child, and observed the SS. The BM, father and child denied the allegations of the report. The BM and father said they had arguments due to the inadequacy of their shelter residence. The BM said she was overwhelmed and the BF said he had a terminal illness. ACS verified the father and children received medical and support services.

Per the progress notes, ACS attempted follow up visits to the family and noted they relocated to permanent housing. In the safety assessment dated 7/18/17, ACS stated the children's whereabouts could not be ascertained. However, ACS did not conduct a diligent search to locate the family.

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

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

Summary:
ACS did not make diligent effort to locate the family prior to completing the Investigation Determination safety assessment document. The case record reflected the family relocated from the shelter to permanent housing. However, in the Investigation Determination safety assessment document, ACS selected the Safety Decision that stated the family refused access to the children.

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:
Failure to Provide Notice of Indication

Summary:
ACS did not provide the Notice of Indication to the BM and father who were the subjects of the 4/12/17 report.

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

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 BM was a subject in five reports registered on 6/26/01, 2/20/03, 8/2/03, 5/10/06 and 10/26/16. The allegations of the five reports were a combination of EN, IG, IF/C/S and LS.

ACS investigated the five reports, substantiated the allegations of IG and LS and unsubstantiated the allegations of EN and IF/C/S. The reports dated 6/26/01, 2/20/03, and 8/2/03, 5/10/06 and were indicated. The 10/26/16 report was unfounded.

Known CPS History Outside of NYS

There was no know history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 07/05/2019

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: 07/05/2019

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?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: The family received PPRS.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☒Yes ☐No

Issue:	Failure to Monitor
Summary:	The FASP did not reflect ACS provided ongoing monitoring of the family following the Elevated Risk Conferences.
Legal Reference:	18 NYCRR 432.2(b)(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:	Timely/Adequate Case Recording/Progress Notes
Summary:	Some progress notes were entered more than 30 days after the event dates.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Preventive Services History

On 7/5/19, ACS opened the preventive services case because the BM said she was overwhelmed with managing the child's behavior and taking care of the two SS. ACS found the child was truant from school, he exhibited defiant behavior, and left the home without the BM's consent. The 8-year-old SS was non-verbal, and wheelchair bound, and he received nursing and home attendant services. The 7-year-old SS received therapeutic services to address his developmental needs. The family received services through a local hospital medical care program.

The FSPN showed the family received PPRS, and during a 10/24/19 home visit the BM requested placement of the child. Per the FSPN, ACS held Elevated Risk Conferences (ERC) on 11/4/19 and 3/26/20. The FSPN reflected the family did not make progress as the BM was unable to prevent the child from leaving the home. The agency observed the child in the home on 3/4/20, and the child said he visited a friend, he apologized for his behavior and said he would not leave the BM's home. According to the FSPN, the agency visited the home on 3/12/20 and 3/18/20 but the child was not available.

The agency completed the number of casework contacts to meet the program requirements. However, the case record did not reflect ACS responded to the BM's request to place the child. ACS and provider agency did not contemporaneously enter progress notes.

Foster Care Placement History

The family received foster care services under an Article Ten Neglect petition that ACS filed in Family Court on behalf of the adult sibling on 2/21/03. The adult sibling was removed from the home and remanded to ACS. He was released to his father on 3/24/07.

The child entered foster care under an Article Ten Neglect petition that ACS filed in Family Court on 5/12/06. During the 5/12/06 hearing, the judge remanded the child to the LDSS. He remained in foster care until he was released to the BM on 7/17/09.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No