Child Fatality Report

Report Identification Number: NY-22-075

Prepared by: New York State Office of Children & Family Services

Issue Date: Mar 02, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 09/12/2022
Initial Date OCFS Notified: 09/12/2022

Presenting Information

An SCR report alleged that on the morning of 9/12/22, the mother was the sole caretaker for the three children, ages 7-years-old, 4-years-old, and 3-months-old. The mother was on the phone with the maternal aunt crying hysterically and stated that she was going to hurt the children. At about 2:00AM, the mother showed up at the father of the 3-month-old's home stating the children were gone, and she had been on the beach with the children. Various family members and local police went to the area along the beach looking for the mother and the children. At 3:17AM, the police located all three children at the shoreline of the beach, unresponsive. Life-saving measures were attempted; however, all three children were pronounced dead at 5:38AM at the hospital.

Executive Summary

An SCR report was received on 9/12/22 regarding the deaths of three siblings that occurred on the same date. This fatality report concerns the death of the 4-year-old female subject child. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother. At the time of their death, the three children, ages 7-years-old, 4-years-old, and 3-months-old lived with their mother. The fathers of each of the three siblings resided outside of the home in their respective residences. The father of the 7-year-old child lived out of state and visited weekly with the child via phone. The father of the 4-year-old child reported having minimal contact with the child as the mother refused to allow visits, but had seen the child the week before her death. The father of the 3-month-old child was believed to have regular contact with the child, though he refused to cooperate with the investigation.

The New York City Administration for Children Services (ACS) completed collateral and casework contacts and learned that on 9/12/22, the mother called the maternal aunt frantic and crying, and would not answer questions about the children’s whereabouts or well-being. The maternal aunt called 911 around 1:25AM, and the mother was later found by relatives walking on a boardwalk without the children. The mother reported to relatives that she drowned the children. The children were located by law enforcement and emergency medical services on the shore of the beach and were unresponsive. Resuscitation efforts were attempted; however, were unsuccessful and the three children were pronounced deceased at 5:38AM.

An autopsy was performed, and the cause of death for all three children was cardiac arrest secondary to drowning. The preliminary findings showed no trauma to any of the children, except an injury to the 7-year-old child’s lip; however, it was reported that the child had been intubated, and the injury could have occurred as a result. The mother was indicted on three counts of 1st Degree Murder and nine counts of 2nd Degree Murder. The criminal investigation remained open at the time the CPS investigation closed, and the mother was incarcerated.

Bereavement and trauma therapy services were offered to the fathers of the children. The fathers of the 7 and 4-year-old children were in contact with a victim assistance organization; however, it was unknown if the fathers were engaged in counseling. ACS did not interview the fathers face-to-face and only spoke to them via phone. The father of the 3-month-old child obtained legal counsel and refused to speak with ACS for the duration of the investigation. The 4-year-old child had two half-siblings that were not assessed during the investigation. The mother was receiving counseling at the correctional facility in which she was located. The mother had no other surviving children. The allegations against the mother were substantiated, and the report was closed on 10/21/22.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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?** No
  - **Safety assessment due at the time of determination?** No
- **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:
ACS made an appropriate determination of the allegations based on evidence obtained throughout the investigation.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
Casework was not commensurate with case circumstances. The 4-year-old child had two surviving half-siblings that were not assessed during the investigation. ACS did not conduct face-to-face interviews with the fathers, and only spoke to them via phone.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The record did not reflect that ACS conducted face-to-face interviews with the fathers and only spoke to them via phone. The 4yo child had two surviving half-siblings; however, there was no documentation that those siblings were assessed.
Legal Reference:	18 NYCRR 432.1 (o)

Action:	ACS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/12/2022 **Time of Death:** 05:38 AM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 01:25 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

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

Total number of deaths at incident event:
Children ages 0-18: 3
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	7 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Month(s)
Other Household 1	Father	No Role	Male	40 Year(s)
Other Household 2	Father	No Role	Male	35 Year(s)
Other Household 3	Father	No Role	Male	32 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS coordinated their efforts with LE, spoke with collateral sources, completed a CPS history check, and interviewed the fathers and relatives.

ACS was initially unable to interview the SM, as she was arrested and held at the hospital for psychiatric evaluation. ACS learned from speaking with relatives, LE, and obtaining dispatch records that on 9/11/22, the SM texted the MA; however, the MA was asleep. When the MA woke in the early hours of 9/12/22, she texted the SM back. The MA then spoke with the SM on the phone, but she was frantic, crying, and ended the phone call. The SM was seen on video footage at the father of the 3-month-old child's home at 2:00AM. The MA called 911 and while on the phone, relatives located the SM on a boardwalk near the beach. The SM was wet, barefoot, and the children were not with her. The SM would not provide relatives with information on the children's whereabouts but stated that she drowned them. LE and EMS responded and located the unresponsive children on the shoreline of the beach. The 7-year-old child was wet, cold, and blue. The 3-month-old child was pale and pulseless, and the 4-year-old child was deceased on arrival. Life-saving measures were attempted but were unsuccessful.

The fathers of the 7 and 4-year-old children were interviewed but did not have information about the fatal incident. The father of the 3-month-old child, who was present when the SM was found and whose home the SM went to at 2:00AM, refused to speak with ACS or provide details about the events preceding the fatalities.

The SM told LE that everything was a bad dream, and the children were with family. When the SM was told what happened and that it was not a dream, the SM broke down and stopped speaking to LE. After being transferred from the hospital to a correctional facility, ACS spoke with the SM, who reported that she did not remember what happened and was working with her attorney to piece together the events leading to the fatalities. The SM made no admissions to LE but did report walking on the beach while holding the 3-month-old child, while one of the other children said "mommy, mommy" and "the waves, the waves."

ACS learned the SM was engaged in mental health counseling prior to the fatal incident. The SM was compliant and had last seen her service provider on 9/2/22. There was no concern for the SM at that time, and the SM had no reported suicidal or homicidal ideation. The SM was diagnosed with depression and had been evaluated for post-partum depression but was not exhibiting signs or symptoms. In her interview with ACS, the SM reported she believed she was suffering from post-partum depression at the time of the deaths. The SM received counseling while incarcerated.

Official Manner and Cause of Death

Official Manner: Homicide
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)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062765 - Deceased Child, Female, 4 Yrs	062769 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
062765 - Deceased Child, Female, 4	062769 - Mother, Female, 30	Inadequate	Substantiated

Yrs	Year(s)	Guardianship	
062766 - Sibling, Male, 7 Year(s)	062769 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
062766 - Sibling, Male, 7 Year(s)	062769 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
062771 - Sibling, Male, 3 Mons	062769 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
062771 - Sibling, Male, 3 Mons	062769 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☒	☐	☐
When appropriate, children were interviewed?	☐	☒	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☒	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The SM was unable to be interviewed face-to-face due to being incarcerated during the investigation. ACS did not attempt to interview the fathers of the 7 and 4yo children face-to-face. The father of the 3-month-old child refused to speak with ACS.

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?	☐	☐	☒	☐
Explain: Although a 24-hour Safety Assessment was completed regarding the SM not having surviving children; ACS did not assess the safety of the 4-year-old child's two half-siblings.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐
Explain as necessary: The 4-year-old child had two surviving half-siblings; however, the record did not reflect any attempts to assess these children during the CPS investigation.				

Legal Activity Related to the Fatality

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

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Murder	**Degree:** 2		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
09/14/2022	The mother	Pending	Pending
Comments:	The mother was indicted on 9 counts of 2nd Degree Murder.		

Criminal Charge: Murder	**Degree:** 1		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
09/14/2022	The mother	Pending	Pending
Comments:	The mother was indicted on 3 counts of 1st Degree Murder.		

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:
ACS offered trauma therapy to all parties. It was unknown if the father of the 7 and 4yo child were engaged in any MH counseling at the time the CPS investigation was closed. The father of the 3-month-old child refused services and was seeking private counseling.

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:
ACS offered the father of the 4yo child services on behalf of the two surviving half-siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Trauma services were offered to the fathers and other family members that ACS spoke with during the investigation. The father of the 3-month-old child refused to speak with ACS and his sister advised ACS he would obtain private counseling. It was unknown if the father of the 7 and 4yo children were engaged in counseling. The SM was receiving MH services through the correctional facility where she was located.

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)
04/22/2022	Sibling, Male, 7 Years	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The SCR report alleged that on an unknown date, for unknown reasons, the BF of the then 1-day-old deceased sibling choked the 7yo deceased sibling. As a result, the 7yo deceased sibling was unable to breathe and had pain to his throat.

Report Determination: Unfounded **Date of Determination:** 06/21/2022

Basis for Determination:
ACS unsubstantiated the allegations of IG, stating that the BF of the then 1-day-old deceased sibling and the SM denied that the incident occurred. The 7yo reported the BF of the then 1-day-old deceased sibling did put his hands around his throat; however, there were no marks or bruises.

OCFS Review Results:
ACS initiated their investigation within 24 hours by contacting the source of the report and conducting a video conference with the 7yo deceased sibling and his father. Home visits were completed upon the 7yo's return to the SM's home. All children were assessed and the 7yo was interviewed. The record did not reflect that the father of the SC was notified of the report in writing or that the SM's mental health provider was contacted regarding the SM's ongoing mental health treatment. ACS documented they received DIRs regarding the SM and BF of the then 1-day-old; however, this was not addressed.

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

Issue:
Failure to provide notice of report
Summary:
The record did not reflect the father of the SC was notified of the report in writing.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
Interviews with the SM lacked key safety-related questions. The SM had a recent MH diagnosis and there was concern she was not taking her medication as prescribed; however, the record did not reflect this was explored with the SM. Despite the SM and BF's denial, ACS obtained LE records that revealed a history of DV. There was no documentation

that the records were discussed with the SM or BF.

Legal Reference:

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

Action:

ACS will prioritize making an adequate assessment of safety and risk to all children in the household and continue an on-going assessment of safety and risk throughout the length of the investigation.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

There a was missed opportunity to gather collateral information from the SM's MH provider. The SM reported being engaged in MH treatment due to a recent MH diagnosis. There was concern the SM was not taking her medication as prescribed, but there was no documentation this was discussed with the provider.

Legal Reference:

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

Action:

ACS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/30/2020	Sibling, Male, 5 Years	Mother, Female, 29 Years	Educational Neglect	Substantiated	Yes
	Sibling, Male, 5 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 2 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

The SCR report alleged the SM was unstable. The SM was overwhelmed and extremely depressed. As a result, the SM was unable to adequately care for the SC and then 5yo deceased sibling. The deceased sibling was not logged on for virtual academic instruction. The SM was aware but refused to ensure that the deceased sibling logged on.

Report Determination: Indicated | **Date of Determination:** 01/29/2021

Basis for Determination:

ACS substantiated the allegation of EdN and unsubstantiated the allegation of IG against the SM. The SM admitted the deceased sibling had not been logged onto his online classes because the SM left the deceased sibling's tablet at the MGM's home. The SM did not get the tablet back because she was overwhelmed and tired. The SM admitted that the deceased sibling received therapy from school and that his absences impacted his performance in a negative way. The CHN were dressed appropriately with clean clothes, and the SM reported the CHN would be supervised by the MGM if the SM needed to run errands. The SM had food, shelter, and clothing for the CHN.

OCFS Review Results:

ACS initiated their investigation within 24 hours of receipt of the SCR report. ACS completed a CPS history check and contacted the source of the report. ACS conducted home visits throughout the investigation. The record did not reflect that the fathers of the SC and deceased sibling were notified of the report in writing. There was no documentation that ACS obtained mental health records for the SM's psychiatric hospitalization or followed up regarding the SM not being engaged in mental health treatment.

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

Issue:

Failure to provide notice of report

Summary:

The record did not reflect that the father of the SC or father of the deceased were notified of the SCR report in writing.

Legal Reference:

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

Action:

ACS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

The record did not reflect that ACS obtained medical records regarding the SM's psychiatric hospitalization, or the SM's MH discharge recommendations, despite supervisory notes stating this was a priority.

Legal Reference:

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

Action:

ACS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Issue:

Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:

ACS learned that the SM did not follow hospital discharge recommendations to engage in outpatient therapy for her ongoing mental health. The record did not reflect that ACS further addressed the SM not being engaged in treatment, despite being aware of the impact the SM's mental health had on the SM's ability to meet the deceased sibling's educational needs.

Legal Reference:

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

Action:

In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. ACS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

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.

Preventive Services History

A preventive services case was opened following the SM being indicated for EdN regarding the 7yo child. The preventive case opened in 1/2021 and closed in 7/2022. The case was opened to continue to address educational needs for the 7yo child, as well as the SM's ongoing MH, DV history, and housing concerns. All FASPs were completed timely. Face-to-face requirements were not met within the first year of the case being opened. The SM had a recent hospitalization due to her MH and was diagnosed with severe depression; however, the preventive services agency did not confirm the SM was engaged in MH treatment until 13 months after the case opened. At the time the preventive case closed, the SM secured

housing, the 7yo child was attending school, and both the SM and 7yo child were engaged in MH treatment. The SM's MH provider had no concerns at the time and noted the SM did not present with suicidal or homicidal ideation. Although the preventive services agency did assist the SM with financial assistance during their last casework contact, the case was closed despite the SM being behind on bills, not receiving her public assistance benefits due to a sanction, and not receiving child support funds. The preventive services agency explored familial and professional resources with the SM; however, the record did not reflect that these collaterals had been contacted to discuss their ability to provide the SM with support prior to the FSS closing.

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