NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-069 **Prepared by: New York City Regional Office**

Issue Date: 12/30/2016

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	

Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
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	

Case Information

Report Type: Child Deceased
Age: 10 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 07/02/2016
Initial Date OCFS Notified: 07/02/2016

Presenting Information

On 7/2/16, the SCR registered a report noting that the 10-year-old SC was autistic, asthmatic, and had sleep apnea. The report alleged that the SC was last seen alive by his father who checked the SC at 1:15 A.M. The father allegedly observed the SC moving in his (SC) bed. The report alleged that the SC was found face down and unresponsive at 3:30 A.M by his mother when she went to change the child's pull-up diaper. The report further noted that the mother called 911, and upon arrival EMS intubated the SC and continued CPR. The SC was transported to Elmhurst General Hospital where he was pronounced DOA. The roles of the two surviving siblings in the home were are unknown.

Executive Summary

The SC was 10 years old when he died on 7/2/16. Due to religious reasons, the family refused to have an autopsy. However, the ME completed an external examination and found no signs of abuse or maltreatment. The ME ruled the cause and manner of death as undetermined.

On 7/2/16, the SCR registered a report concerning the death of the SC with allegations of DOA/Fatality and Inadequate Guardianship of the child by the parents.

ACS contacted the family within the required timeframe and assessed the surviving siblings were safe in the care of the parents.

ACS made a visit to the home and found there were appropriate provisions for the children. Due to the SC's medical condition and aggressive behaviors, he had his own room. The siblings shared a room with the BM and the BF slept in the living space.

There was no apnea monitor or nebulizer in the home. The BM said the SC broke the apnea monitor and they did not have it replaced since the SC would never stay still long enough to have the device on, especially in his sleep.

According the parents they were celebrating a religious holiday, the BF arrived from his place of worship at 1:30A.M., and at that time the SC was alive. Between 3:00 A.M. and 3:30 A.M., as the parents were going to eat breakfast, they noticed the SC was unresponsive. The parents noted that they called 911 and the EMS responded to the case address. Neither parent had an explanation for the SC's death. The parents mentioned the SC had a slight fever on 7/1/16 through 7/2/16 when the BF arrived at the home. The BF stated they intended to take the SC to the ER for the fever if it persisted. The parents did not give the SC any medication for the fever and there was no indication that they monitored the SC's temperature.

ACS did not explore with medical staff or the ME whether cause of the fever could have contributed to the SC's death.

The doctor from Elmhurst Hospital noted the SC arrived at the ER with no signs of life and attempts of resuscitation

failed.

The NYPD indicated the 911 call was made at 4:11 AM. EMS was on the scene at about 4:16 AM., and the NYPD arrived at the location at 4:17 AM. EMS transported the SC with the BF to Elmhurst Hospital where the SC was pronounced dead at 5:11 A.M. Neither, the NYPD, medical staff from Elmhurst Hospital or the ME found any indication of abuse or neglect of the SC. Although there were no safety concerns about the surviving siblings, as per protocol, ACS held a CSC and discussed the parents difficulty with managing the SC's behavior, his health and other concerns about the siblings. The parents accepted services for the siblings and were referred for PPRS.

ACS obtained a copy of the death certificate issued by the OCME which listed the cause of death as undetermined.

On 8/10/16, ACS unfounded the report based on the information provided by the ME which indicated there was no trauma to the body and no signs of abuse or neglect. ACS also cited the NYPD found no criminality surrounding the SC's death. The case remained open for preventive services as the family requested educational and transportation assistance for the siblings.

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?** No

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:
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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-Hour Report did not include relevant information gathered during the initial 24 hours of the investigation.
Legal Reference:	CPS Program Manual, VIII, B.1, page 2
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	ACS selected safety decision #2 and noted the family's history as a safety factor. However, the previous cases were unfounded and the comments did not specify how the parents were unwilling or unable to protect the surviving siblings children.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	ACS selected safety decision #2 for the and noted the family's history as a safety factor. The previous cases were unfounded and the comments did not specify how the parents were unwilling or unable to protect the surviving siblings.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/02/2016 **Time of Death:** 05:11 AM

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? Yes
Time of Call: 04:11 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A

Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 2 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1

At time of incident supervisor was:

☐ Drug Impaired ☐ Absent
☐ Alcohol Impaired ☒ Asleep
☐ Distracted ☐ Impaired by illness
☐ Impaired by disability ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	10 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	59 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

Following the fatality report, ACS made contact with the NYPD, medical staff from Elmhurst Hospital, pediatrician, and the ME. Based on these collateral contacts, there was no indication of abuse or maltreatment. The NYPD noted there was no criminality suspected in the death of the SC.

The BM indicated that on 7/1/16 at about 6:00 P.M. and 7:00 P.M. the SC was lying on the bed and by the touch of her hand she felt the child was warm. The BM said she did not give the SC any medicine for what she believed was a light fever. The BM said she woke up at about 3:30 A.M on 7/2/16 to prepare breakfast for the family and began calling the SC to come to the kitchen. The BM said the SC did not respond so she went to his room to wake him, but found him unresponsive. The BM said the SC was lying on the bed with his mouth and eyes open and his face was “bluish.” The BM said the SC was lying on his left side and his face was “turned up.” The BM said she began to scream, and the BF ran to the SC’s room. The BM said she “pushed” the SC’s chest and no breath came from the child. The BF called 911 and EMS responded and transported the SC to the hospital.

The BM said the SC was given an apnea monitor in 2013 after he was taken to the ER for respiratory problem, but she

brought the SC home without the monitor because the SC broke it the same day at the hospital. The BM said she did not mention it to the SC's pediatrician because if the SC was given another one the SC would break it too. The BM noted the SC was aggressive and uncontrollable. The mother stated the SC had a respiratory condition since birth, and began to rapidly gain weight when he turn two. The sC's weight at the time of death was not documented.

ACS contacted the children's doctor who indicated the SC was diagnosed with a medical condition, developmental delay, was very aggressive and not verbal. The doctor noted the parents complained about the SC's aggressive and "out of control" behavior. The doctor stated the SC had exhibited this aggressive behavior in the medical office. The doctor explained how the SC's behavior impacted the parents' ability to utilize medical equipment that had been prescribed to the SC. The doctor said the parents had inquired about placing the SC in a long term care facility. ACS did not document the doctor's response to the parents' request. There were no major concerns documented concerning the siblings.

ACS surmised that medical staff who had treated the SC throughout the years did not insist on the parents utilizing the apnea monitor for the child. ACS' contact with the SC's doctor supported the parents' response. However, the doctor was not asked how the SC's condition was expected to be treated. It was not clear whether this assessment was based on the doctor's response or if it included the SC's medical records from the hospital which ACS had requested. The concerns about the lack of use of the apnea monitor were not discussed with the ME as a possible contributor to the SC's death.

There were no safety concerns documented concerning the siblings. However, as per protocol, ACS held a CSC which mostly focused on the parents' challenges in managing the SC's behavior. According to the parents, the SC was aggressive to them and the siblings. The BF expressed he wanted to have the SC placed during the 2013 investigation due to his behavior and alleged that ACS informed him his other children would also be placed.

ACS reviewed the SC's and the 8-year-old's attendance record and found they were absent for most of October 2015. The parents noted that they travelled to their native country for no specific reason.

ACS assessed that the parents were not neglectful but appeared to have experienced language barriers when meeting with doctors to discuss issues concerning the SC. ACS noted this barrier prevented the parents from being educated on how to best deal with the SC's behavior.

On 8/10/16, ACS unfounded the report.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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
029621 - Deceased Child, Male, 10 Yrs	029622 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
029621 - Deceased Child, Male, 10 Yrs	029623 - Father, Male, 59 Year(s)	DOA / Fatality	Unsubstantiated
029621 - Deceased Child, Male, 10 Yrs	029622 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
029621 - Deceased Child, Male, 10 Yrs	029623 - Father, Male, 59 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

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

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine

Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

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

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	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☒	☐	☐	☐	☐	☐	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☒	☐	☐	☐	☐	☐	☐
Other, specify: PPRS							
Additional information, if necessary: N/A							

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? N/A

Explain:

There were no immediate needs for the surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate needs for the parents.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	No
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)	Status/Outcome	Compliance Issue(s)
09/09/2013	10541 - Deceased Child, Male, 7 Years	10532 - Mother, Female, 32 Years	Inadequate Guardianship	Unfounded	Yes
	10541 - Deceased Child, Male, 7 Years	10533 - Father, Male, 45 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The report noted the SC was autistic and would act out in a physical manner. The report alleged that the BM would tie the SC's legs to prevent him from kicking his sibling. The BM denied this allegation, and the matter was not explored further with the source.

On 9/9/13, the SC was taken to the hospital by the matron from the school bus because he was hitting children on the bus and the staff was unable to restrain him. It was alleged that the parents refused to take the SC home from the hospital. The BF admitted that, out of anger, he threatened he was not taking the SC home but returned to the hospital once he calmed down. The BF said he was unaware that the SC was autistic.

Determination: Unfounded | **Date of Determination:** 10/29/2013

Basis for Determination:
ACS unsubstantiated the allegation of IG against the parents based on the fact that the BF returned to the hospital to be with the SC. ACS noted that there was no credible evidence to indicate the report against the parents.

However, ACS did not explore the parents' failure to attend services to learn how to care for the SC who had medical and special needs. ACS and the school made referrals for the parents to seek help to manage the special needs of the SC, but

they did not follow through.

OCFS Review Results:

The investigation was not thorough as interviews with the collateral contacts focused on obtaining information about the children and not the parents' ability to care for them. ACS did not explore with the parents, SC's pediatrician or school staff the parents' ability or understanding of the SC's medical needs concerning his autism, apnea or asthma. There was also no contact with family or community members to explore the parents' support system.

ACS did not address with the parents their failure to utilize resources of the referrals previously made by ACS or the school staff to help them manage the SC's behavior.

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

Interviews with the collateral contacts focused on obtaining information about the children and not assessing the parents' ability to care for them and/or the SC's special needs. The mother denied that she would tie the SC's legs to protect the sibling, but ACS did not re-address this issue with the source.

Legal Reference:

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

Action:

ACS must meet with the staff involved in this investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The safety decision (#2) selected noted that safety factors existed, but did not rise to the level of immediate or impending danger of serious harm. However, the comments for the safety factors selected did not include an explanation of the parents' inability to care for the children.

Legal Reference:

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

Action:

ACS must meet with the staff involved in this investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

There were discrepancies concerning the parents' knowledge of the SC's diagnosis based on the ACS' interviews with the parents and the SW. The children were 4- and 7-years-old and weighed 117 and 114 pounds, respectively. There was no discussion with the pediatrician concerning this matter. A random review noted the children were "misdiagnose" but was not specific concerning this matter.

Legal Reference:

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:

ACS must meet with the staff involved in this investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

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

Summary:
Several questions listed in the risk assessment profile did not reflect appropriate responses. In addition, there was no assessment of risk as it pertained to the children's health, specifically the SC who reportedly suffered from sleep apnea and was significantly overweight. It was not specified whether the SC was prescribed any equipment for the apnea.

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

Action:
ACS must meet with the staff involved in this investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

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

The parents were listed as the subjects of a SCR report dated 10/10/11 for allegations of Burns and Scalding of the then 5-year-old SC and Inadequate Guardianship of the SC and his then 2- year-old sibling.

ACS' investigation gathered that the SC sustained 10% burn on his lower back (above his buttocks) and 2nd degree burns to the back of his scalp. The mother explained that she made a pot of lentil soup and turned away for a moment when the 2-year-old sibling climbed up on a chair and pulled the handle of the pot. The SC was standing with his back to the stove and the contents of the pot spilled on him. The attending physician reported that the mother's explanation was plausible and determined that the incident was accidental. The father was not home at the time of the incident.

ACS found no concerns of abuse or maltreatment of the children. However, ACS assessed the children had behavioral problems and delays and referred the family for services with a community based organization.

On 12/9/11, ACS unsubstantiated the allegations of the report based the determination made by the medical staff who indicated that the incident was accidental.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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