NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-035 **Prepared by: New York City Regional Office**

Issue Date: 11/28/2016

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: 1 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 09/27/2014
Initial Date OCFS Notified: 04/13/2016

Presenting Information

The 4/13/16 report alleged that on an unknown date in 2014, one of the parents, either the mother or father, was co-sleeping in a bed with the 3-month-old infant. One of the parents rolled over on the infant and the infant suffocated. The infant was pronounced dead by medical staff. The 5-year-old and 2-year-old children were removed from the parents' care after the infant's death.

The report stated the mother gave birth to an infant approximately three months ago and this infant resides in the home with both parents. The report further alleged there was ongoing verbal and physical violence in the presence of the infant. Loud banging was heard coming from the apartment. The report further alleged that both parents were abusing alcohol and cocaine; were too impaired and intoxicated to provide adequate care for this infant, and that the situation was ongoing.

Executive Summary

The allegations of the 4/13/16 report were DOA/Fatality and IG of 1-month-old male infant, IG of the 4-year-old and 7-year old and IG and PD/AM of the 4-month-old surviving children by the parents.The infant died on 9/27/14. The autopsy listed the cause of death as overlay and the manner of death as accident (co-sleeping with toddler sibling on couch).

The SCR had previously registered a report concerning the infant’s death on 9/27/14. OCFS issued fatality report NY-14-102 pertaining the fatality. ACS addressed the citations of timeliness and adequacy of required documents, assessment of need for Family Court action, application of legal standards, eligibility for PPRS, mandated reporter education identified in the NY-14-102 report. OCFS accepted the ACS action plan on 12/10/15.

As part of the investigation, ACS made contact with the building superintendent where the family resided and learned that there were reports of continuous alcohol and cocaine misuse by the parents. The superintentent said the parents engaged in physical fights while the newborn infant was in the home. He reported that concerned individuals had contacted LE about the parents' behavior. According to ACS, a remand of the surviving infant was conducted on 4/19/16 as the respondent parents had not complied with the service plan.

The Investigation Summary of the 4/13/16 report reflected that ACS added allegations of PD/AM of the then 3-year-old and 6-year-old children and also added the then 9-year-old with allegations of IG and PD/AM by the subjects. For the report dated 4/13/16, ACS completed the 24-hour safety assessment on 4/15/16.

Initially, ACS substantiated the allegation of DOA/Fatality on the 9/27/14 report, but unsubstantiated the same allegation on the 4/13/16 report. The Investigation Conclusion for the 4/13/16 report stated that the infant’s death was due to natural causes. This was inaccurate as the autopsy report listed the cause of death as overlay and the manner of death as accident (co-sleeping with toddler sibling on couch).

On 6/15/16, ACS unsubstantiated the allegation of DOA/Fatality, but substantiated the allegations of PD/AM and IG of the 4-month-old, then 1-month-old infant (now deceased), 3-year-old, 6-year-old, 9-year-old children. ACS based the decision on the parents' history of and continued substance and alcohol abuse, domestic violence in the presence of the children, and the parents' inability to provide adequate care for the children. Additionally,the parents had enrolled in several drug and alcohol programs but did not comply with the program requirements. They continued to be non-compliant with court ordered services which resulted in the children being removed in 2014. On 9/27/14, the 1-month-old infant was found unresponsive and later pronounced dead.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** No

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:
NA

Required Actions Related to the Fatality

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

Issue:	Adequacy of case recording
Summary:	ACS added to the CPS Investigation Summary the allegation of PD/AM of the then 3-year-old and 6-year-old and IG and PD/AM of the then 9-year-old by the subjects. However, ACS did not list the new data in the Allegation Information list.
Legal Reference:	18 NYCRR 428.5(c)

Action:	ACS must submit a corrective action plan 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:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	During the 9/27/14 investigation, ACS Sub the allegation of DOA/Fatality However, ACS Unsub the DOA/Fatality allegation for the 4/13/16 investigation. ACS did not provide new findings to justify the decision to change the determination.
Legal Reference:	SSL 412(1) and 412(2)
Action:	ACS must submit a corrective action plan 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 24 Hour Assessment
Summary:	For the report dated 4/13/16, ACS completed the 24-hour safety assessment document on 4/15/16.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/27/2014 **Time of Death:** 08:20 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: 08:08 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

Is the caretaker listed in the Household Composition? Yes - Caregiver 1

At time of incident supervisor was:

- ☐ Drug Impaired
- ☒ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☐ Asleep
- ☐ Impaired by illness
- ☐ 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	9 Year(s)

LDSS Response

ACS made contact with the building superintendent who stated that in 2014 a neighbor had supervised the infant who died. This neighbor had observed the parents under the influence of drugs/alcohol. The neighbor expressed concerns for the surviving infant due to the parents' ongoing drug/alcohol misuse and domestic violence incidents.

On 4/13/16, the parents were interviewed. The mother only had the surviving infant in her care. The mother reported that her eldest child had been residing with the MGM since she was very young through a family arrangement. The then 3-year-old and 6-year-old children were removed by ACS and remained in the MGM's care. The SM admitted she and the father had a verbal dispute a few days prior to 4/13/16 and LE became involved but denied domestic violence.

The SM had a history of alcohol abuse while caring for her children, one of whom died while in her care in 2014. The SM also had a history of non-compliance with the service plan. The SM participated in a three-day intake process with a program on 3/7/16. The SM completed the intake process on 3/29/16, she enrolled in the program but subsequently missed several scheduled appointments. She claimed she and the SF had several Human Resource Administration (HRA) appointments during the day but she made no effort to make up the sessions during evening hours. The mother denied she used alcohol since the death of her child in 2014.

The SF acknowledged he had arguments with the SM but denied there were fights between himself and the SM. The SF said about three weeks prior to 4/13/16, LE visited the home as a result of contact from a concerned individual. The SF said he did not know the reason the individual contacted LE. SF said LE told him that they were responding to a noise

complaint issue. LE left after they learned there was no issue. SF denied being involved with drugs and DV.

The MGM informed ACS that she did not have information about the parents' relationship. The 5-year-old child said the SM visited her accompanied by the surviving infant sibling. She said the PGF took her to visit the father. This child described an incident where the father punched the mother in the mouth and ACS involvement. She also said that if the SM did not stop drinking she was going to die.

The SM's counselor at the rehabilitation center said the SM completed the intake process on 3/29/16. She was drug tested on 3/29/16 and 4/5/16; both test results were negative. She missed appointments on 4/2/16 and 4/8/16. Later, ACS was informed that the SM should be referred to a different program. The concern was that due to the mother's inconsistent attendance, the program was unable to adequately monitor her level of usage within 24-hour timeframes. Both of the parent's non-compliance and poor attendance made it impossible to make accurate clinical assessments.

According to the ACS staff, a remand of the infant was conducted on 4/19/16 as the respondent parents did not cooperate with services. The infant was released to the MGM with Court Ordered Service (COS). A full temporary order of protection was initiated on behalf of the infant against the parents. The two siblings, who had been placed in non-kinship foster care since the 9/27/14 investigation, and the half sibling were released to the MGM with COS. Later, the two children were reunited in the MGM's home with the half sibling. Documentation reflected the children were in the legal care and custody of the MGM and visited regularly with the PGM out of state. The Family Court directed ACS to submit an Interstate Compact on the Placement of Children (ICPC) application to out of state to consider granting custody of the children (the then 3 and 6 year old) to PGM.

Documentation reflected that the parents were referred for community based services. The parents continued to be non-compliant with the service plan.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
030645 - Sibling, Female, 3 Year(s)	030644 - Mother, Female, 25	Inadequate Guardianship	Substantiated

	Year(s)		
030645 - Sibling, Female, 3 Year(s)	030643 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
030645 - Sibling, Female, 3 Year(s)	030643 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030645 - Sibling, Female, 3 Year(s)	030644 - Mother, Female, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030646 - Sibling, Male, 6 Year(s)	030643 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030646 - Sibling, Male, 6 Year(s)	030644 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
030646 - Sibling, Male, 6 Year(s)	030643 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
030646 - Sibling, Male, 6 Year(s)	030644 - Mother, Female, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030647 - Sibling, Female, 9 Year(s)	030643 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
030647 - Sibling, Female, 9 Year(s)	030643 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030647 - Sibling, Female, 9 Year(s)	030644 - Mother, Female, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030647 - Sibling, Female, 9 Year(s)	030644 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
030921 - Deceased Child, Male, 1 Month(s)	030644 - Mother, Female, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030921 - Deceased Child, Male, 1 Month(s)	030643 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030921 - Deceased Child, Male, 1 Month(s)	030643 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
030921 - Deceased Child, Male, 1 Month(s)	030643 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
030921 - Deceased Child, Male, 1 Month(s)	030644 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
030921 - Deceased Child, Male, 1 Month(s)	030644 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
030922 - Sibling, Male, 3 Month(s)	030643 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
030922 - Sibling, Male, 3 Month(s)	030643 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030922 - Sibling, Male, 3 Month(s)	030644 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
030922 - Sibling, Male, 3 Month(s)	030644 - Mother, Female, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:

There were progress notes not entered contemporaneously.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
ACS documentation reflected that the three children were placed with the MGM. A remand of the surviving infant was conducted on 4/19/16 as the respondent parents had not complied with the service plan.

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**

04/19/2016	There was not a fact finding	There was not a disposition
Respondent:	030643 Father Male 35 Year(s)	
Comments:	Documentation reflected that the Family Court entered into a finding of Neglect against the respondent parents. The Family Court ruled that the parents' failure to provide the children with proper shelter and proper supervision/guardianship by misusing drug/alcohol, which lead to the death of the infant while in their care. A dispositional order was entered on 10/21/15. The respondent parents were to comply with ACS supervision, cooperate with random drug screenings, enroll and complete substance abuse program, enroll and complete parenting skills and submit to clinical health assessments. The parents were not in compliance and the mother gave birth to another infant. An Article Ten Petition was filed.	

Have any Orders of Protection been issued? Yes	
From: 10/02/2014	**To:** Unknown
Explain: The Family Services Progress Notes reflected that a temporary full stay away order of protection (OOP) was issued against the respondent mother and father on behalf of all children, except for supervised visits.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☒	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☒	☐	☐	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☒	☐	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐

Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The school staff referred the half sibling, who was then nine years old, to a family worker for counseling services. Safe Horizons confirmed that the family would receive counseling with their agency. The parents were referred to a community based organization. However, the parents did not comply with the attendance requirements.

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 family had an open PPRS case at the time of the fatality. The family received preventive and foster care services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family had an open PPRS case at the time of the fatality. The parents received case management services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/12/2013	10747 - Sibling, Male, 5 Years	10745 - Mother, Female, 25 Years	Educational Neglect	Indicated	Yes
	10747 - Sibling, Male, 5 Years	10745 - Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Indicated	
	10748 - Sibling, Female, 2 Years	10746 - Father, Male, 35 Years	Inadequate Food / Clothing / Shelter	Indicated	
	10748 - Sibling, Female, 2 Years	10745 - Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Indicated	
	10747 - Sibling, Male, 5 Years	10745 - Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Indicated	
	10748 - Sibling, Female, 2 Years	10745 - Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Indicated	
	10747 - Sibling, Male, 5 Years	10746 - Father, Male, 35 Years	Educational Neglect	Indicated	

Report Summary:
The 12/12/13 SCR report alleged that the male sibling, who was then five years old, was absent 22 days and late on 17 occasions. The report also alleged that the male sibling was in Kindergarten and failing. He was also in being evaluated for educational support services but did not complete the process. The mother had a drinking problem that prevented her from getting up in the morning to bring the sibling to school.

Determination: Indicated | **Date of Determination:** 02/07/2014

Basis for Determination:
ACS based the determination on investigative findings which showed the mother was intoxicated on two occasions. During the home visits the home was found to be filthy and the parents had no explanation. The parent did not work and the mother was home all day. The mother had to be asked to clean up her home environment. The 5-year-old sibling missed 23 days of school and failed classes. ACS assisted the family with transferring this sibling to a local school in the parents' neighborhood. ACS found the parents kept a dirty home and it perhaps contributed to the drinking habits of the parents. The father did not work and had no explanation for the sibling's excessive school absences.

OCFS Review Results:
The 12/12/13 investigation was initiated in a timely manner. During a home visit, the Specialist observed a hot plate which the mother said she used to prepare meals as there was no gas service. The Specialist did not address the utility issue with the parents despite the same condition existed during the 9/14/13 investigation. ACS held two child safety conferences (CSC); one CSC was held after ACS obtained evidence there was an alcohol odor on the mother's breath. ACS did not seek a legal consultation to request Court Ordered Supervision of the family.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
During the 12/12/13 investigation, the Seven Day and Investigation Determination safety assessments were inconsistent as the Specialist documented no safety factors placed the children in immediate or impending danger although the safety decision selected was one or more Safety Factors placed the children in immediate or impending danger of serious harm.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must submit a corrective action plan 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:
Eligibility for Preventive Services
Summary:
The Initial FASP dated 1/11/14 and completed by ACS reflected the service plan addressed the parents substance misuse which had a negative impact on their ability to manage the welfare of their children. However, the case circumstances did not support the selection of parent unavailability for mandated preventive services.
Legal Reference:
18 NYCRR 423.3 and 430.9
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Appropriateness of allegation determination
Summary:
The CPS Investigation Summary Allegation Information reflected allegations of EN, IF/C/S and PD/AM but the Investigation Conclusion Narrative did not include narrative to support the agency's decisions regarding the allegations of IF/C/S.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/14/2013	10725 - Sibling, Female, 8 Years	10721 - Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unfounded	Yes
	10725 - Sibling, Female, 8 Years	10722 - Father, Male, 34 Years	Inadequate Guardianship	Unfounded	
	10724 - Sibling, Male, 5 Years	10722 - Father, Male, 34 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10724 - Sibling, Male, 5 Years	10722 - Father, Male, 34 Years	Inadequate Guardianship	Unfounded	
	10725 - Sibling, Female, 8 Years	10722 - Father, Male, 34 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10725 - Sibling,	10722 - Father, Male,	Parents Drug / Alcohol	Unfounded	

Female, 8 Years	34 Years	Misuse	
10723 - Sibling, Female, 2 Years	10721 - Mother, Female, 25 Years	Inadequate Guardianship	Unfounded
10723 - Sibling, Female, 2 Years	10721 - Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unfounded
10724 - Sibling, Male, 5 Years	10721 - Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded
10725 - Sibling, Female, 8 Years	10721 - Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded
10725 - Sibling, Female, 8 Years	10721 - Mother, Female, 25 Years	Inadequate Guardianship	Unfounded
10723 - Sibling, Female, 2 Years	10721 - Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded
10724 - Sibling, Male, 5 Years	10721 - Mother, Female, 25 Years	Inadequate Guardianship	Unfounded
10724 - Sibling, Male, 5 Years	10721 - Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unfounded
10723 - Sibling, Female, 2 Years	10722 - Father, Male, 34 Years	Inadequate Food / Clothing / Shelter	Unfounded
10723 - Sibling, Female, 2 Years	10722 - Father, Male, 34 Years	Inadequate Guardianship	Unfounded
10723 - Sibling, Female, 2 Years	10722 - Father, Male, 34 Years	Parents Drug / Alcohol Misuse	Unfounded
10724 - Sibling, Male, 5 Years	10722 - Father, Male, 34 Years	Parents Drug / Alcohol Misuse	Unfounded

Report Summary:
The parents did not maintain a safe and sanitary living environment for the three children. The home was filled with clutter and garbage, including old food. There was no place to walk in the home because of the clutter and there was a strong unpleasant odor in the home. The home was infested with flies. The parents were impaired by unknown substances. During the night, the parents engaged in a physical altercation, details were unknown. As a result the father sustained injuries.

Determination: Unfounded | **Date of Determination:** 11/08/2013

Basis for Determination:
ACS based the determination on investigative findings which showed the children's basic needs for food, clothing, and shelter were being met by the parents. The mother submitted to a drug screen which returned negative for all substances. The father did not submit to a blood test. The Specialist did not observe drug or alcohol paraphernalia in the home. The parents and children denied there was domestic violence in the home. A criminal record background check revealed there was no Domestic Incident Reports (DIR). The Specialist addressed the issues of cleanliness of the home with the family and observed an improvement in the home condition.

OCFS Review Results:
The 9/14/13 investigation was initiated timely. On the same day, the supervisor documented that on 9/14/13, another Specialist interviewed the half sibling. However, the ACS case record did not reflect this interview occurred. Also, during the investigation, the parents informed ACS that the family experienced financial difficulty: the family had significant rent arrears and overdue bills. The mother stated the housing management company planned to take the family to court regarding the rent arrears. ACS documentation did not reflect the agency explored the cause of the financial

arrears, available family finances and budgeting practices.

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

Issue:

Appropriate Application of Legal Standards (Abuse/Maltreatment)

Summary:

The ACS determination was not consistent with the 9/20/13 safety assessment that reflected the home was observed to have unsanitary conditions: including dozens of flies, dirty refrigerator, piles of clothing throughout the home and cat feces. ACS did not apply the legal standards of maltreatment when addressing the allegations of IG and IF/C/S.

Legal Reference:

SSL 412(1) and 412(2)

Action:

ACS must submit a corrective action plan 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:

Determination of Nature, Extent and Cause of Conditions (Report)

Summary:

ACS documentation reflected the family had significant rental arrears and outstanding bills. However, ACS did not fully explore the family's finances with the parents to determine the cause of these arrears given that there was an allegation of PD/AM of the children by the parents.

Legal Reference:

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

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/21/2011	10717 - Sibling, Female, 8 Months	10714 - Mother, Female, 23 Years	Inadequate Guardianship	Unfounded	Yes
	10716 - Sibling, Male, 3 Years	10715 - Father, Male, 32 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10717 - Sibling, Female, 8 Months	10715 - Father, Male, 32 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10716 - Sibling, Male, 3 Years	10714 - Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10716 - Sibling, Male, 3 Years	10714 - Mother, Female, 23 Years	Inadequate Guardianship	Unfounded	
	10717 - Sibling, Female, 8 Months	10714 - Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	10716 - Sibling, Male, 3 Years	10715 - Father, Male, 32 Years	Inadequate Guardianship	Unfounded	
	10717 - Sibling,	10715 - Father, Male,	Inadequate Guardianship	Unfounded	

Female, 8 Months	32 Years		

Report Summary:
The parents resided in a home in which they exposed the children to a dirty environment. The parents made no effort to clean the home for the safety and welfare of their children. The parents smoked cigarettes and left the butts accessible to the children. There was filth and debris on the floors of the home. The children had poor hygiene. This behavior was ongoing.

Determination: Unfounded | **Date of Determination:** 12/20/2011

Basis for Determination:
ACS based the determination on the finding that the parents ensured they created a healthy home environment for the children. The parents met the basic needs of food, clothing and permanent shelter for the children. The children were not placed at risk of being malnourished or mistreated in the home. The parents actions did not place the children at risk of being hurt or harmed in the home. The home was initially observed to be somewhat untidy but it did not meet the criteria of being a safety hazard.

OCFS Review Results:
The investigation was initiated timely. Although the ACS case record showed the surviving female sibling was then ten-months old, ACS' documentation did not reflect safe sleep practices were discussed with the parents. Also, ACS did not update the CONNECTIONS household composition to reflect the accurate case address. In addition, ACS inappropriately completed the Investigation Conclusion Narrative as the agency did not include justification for the decision to unsubstantiated the allegations pertaining to the half sibling (who was then six years old).

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

Issue:
Adequacy of case recording

Summary:
During the investigation of the 10/21/11 report, ACS identified the MGM's home as the case address. However, in the CPS Investigation Summary, ACS listed a different address for the family. Although ACS referred the family to the Prevention Assistance for Temporary Housing program, ACS did not provide adequate follow up casework activity regarding the family's unstable housing situation.

Legal Reference:
18 NYCRR 428.5(c)

Action:
ACS must submit a corrective action plan 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.

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

The parents were known as subjects in a report dated 6/21/10. The allegations of the report were IF/C/S and IG of the surviving sibling and half sibling by the parents. ACS unsubstantiated the allegations of the report after the findings showed the parents provided adequate care of the children. ACS noted the children's basic needs were met. ACS closed the investigation stage of the case and the agency referred the family for preventive services to assist the mother with obtaining and maintaining income, accessing affordable housing and ensuring the sibling obtained the required evaluation. The mother received referral for counseling/mentoring.

Known CPS History Outside of NYS

There was no known 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: 12/12/2013

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 12/12/2013

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

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Explain: ACS did not develop a plan to address the safety factors that placed the children in immediate or impending danger.				

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The most recent FASP was the FASP of 7/10/16. It was not approved until 8/10/16.				
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:
Preventive services were provided by the Women's Prison Association (WPA). The family had an open PPRS case at the time of the fatality. The fatality occurred 9/27/14 and was previously investigated by ACS. OCFS issued report NY-14-102 on 3/26/15.

Required Action(s)

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

Issue:	Timeliness of completion of FASP
Summary:	The most recent FASP was due on 7/10/16. It was not approved until 8/10/16.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must submit a corrective action plan 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

As a result of the 6/21/10 investigation, ACS determined the family needed preventive services to maintain household functioning. On 8/20/10, ACS opened the Family Services Stage (FSS) and referred the family to the Puerto Rican Family Institute (PRFI) agency. On 9/3/10, the mother agreed to participate in individual and family counseling, obtain and maintain permanent housing and obtain evaluation for the sibling. On 4/26/12, the CP made the required referral. However, the mother elected to have the evaluation completed at a later date. The mother applied for NYC housing and was placed on a waiting list. The CP addressed with the mother the home management concerns and use of parenting aide. The CP counseled the mother about maintaining a clean and well organized home. The mother refused to participate in parenting class. On 5/15/12, the FSS was closed as services were no longer needed.

On 12/12/13, ACS opened the FSS and referred the family to the Women's Prison Association agency for PPRS. On 1/13/14, a joint home visit occurred and on 1/16/14, the mother signed an agreement to accept services. The Initial FASP reflected the parents misused substances and they did not adequately manage the home. On 9/23/14, the CP last observed the infant and surviving children in the MGM's home. The children were fine. The mother was not in the home.

Required Action(s)

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

Foster Care Placement History

There is no record of foster care placement 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?
☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
Unknown	Adjudicated Neglected	Care/Custody to Local Social Services District
Respondent:	030644 Mother Female 25 Year(s)	
Comments:	Documentation reflected that the Family Court entered	

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