NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-040 **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: 4 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 04/21/2016
Initial Date OCFS Notified: 04/21/2016

Presenting Information

The 4/21/16 report alleged that the mother was in the same bed with the 4-month-old infant and her two younger daughters. They all slept with pillows and blankets. On 4/21/16, at around 5:30 AM, the mother woke up and found the infant unresponsive with fluid coming out of her nose and mouth. The mother and grandmother tried to wake the infant and could not. The emergency number 911 was called, and under the direction of the 911 operator, the mother and grandmother attempted CPR until the ambulance arrived. The infant was taken to the hospital and pronounced dead at 6:00 AM. There was no explanation for the infant's death and she had no preexisting medical condition. She was an otherwise healthy infant. The mother, grandmother and unrelated home member were responsible and had access to the infant at the time of death.

Executive Summary

The 4-month-old female infant died on 4/21/16. As of 11/14/16, NYCRO has not received the autopsy report.

The allegations of the 4/21/16 report were DOA/Fatality and IG of the infant by the SM, MGM and unrelated home member (UHM). ACS added to the report the allegation of IG of the surviving twin infant B and 2-year-old child by the SM, MGM and UHM. The SCR registered two subsequent reports on 4/21/16. These reports included the allegations of DOA/Fatality and IG of the infant and IG of the siblings.

ACS investigation revealed the children went to sleep at about 11:00 PM on 4/20/16. The SM, 2-year-old child, and twin infants slept vertically on the full size bed. SM placed a pillow at the end of the bed on the right side; the twins were propped up by three pillows, two small square throw pillows and one standard pillow while another pillow separated the twins from the 2-year-old child. The 2-year-old child and SM were at the end of the bed on the left side. The SM and children slept on top of the comforter. The SM used knit blankets for the children. The SM said pacifiers were used that night. The SM said she checked the children before falling asleep and observed there was a pacifier in each child’s mouth. When the SM woke, the infant’s (deceased) pacifier was on the bed next to her. The two MUs were on a bottom bunk bed and the MGM and her UHM slept on a mattress. The SM said the last time she saw the infant alive was at about 12:00 AM. Before she went to bed, she checked the children and everyone was fine. The SM woke at about 5:00 AM and observed the infant was not responsive. SM was still on the left side of the bed and the 2-year-old child was curled up underneath her. The 2-year-old was not on top of the infant and she denied waking on top of her. SM stated that everyone awoke in the positions which they all went to sleep. The SM said she observed the twins were on their backs but the infant had blood coming from her nose and white foam from her mouth. SM called out to the MGM and alerted her that there was something wrong with the infant. The MGM woke and told the UHM to call 911.

The documentation showed the 24 Hour safety assessment for the 4/21/16 fatality investigation was not completed until 4/29/16. The 24-Hour, 7-Day and Investigation Determination safety assessments included comments that did not support the selected safety factors.

On 6/27/16, ACS Unsub the allegation of DOA/Fatality by the SM, MGM, and UHM on the basis of lack of credible evidence. ACS added that the ME's findings were leaning towards the cause and manner of death as Undetermined in relation to the co-sleeping.

ACS Sub the allegation of IG of the SM's three children by the SM, MGM, and UHM on the basis that the SM admitted to co-sleeping with the children the night of the infant's death. SM slept in a full size bed with the twin infants and 2-year-old child. The SM and MGM failed to provide the children with adequate sleeping arrangements, although the family had the money to do so, that would ensure safe sleeping. The SM and UHM were illegally residing with the MGM and siblings in a shelter. SM and MGM did not inform shelter staff that the SM and children were living with the MGM, which would have permitted the shelter to provide the family with adequate sleeping arrangements. The SM and MGM created the environment that led to the death of the infant. The UHM was aware the SM was co-sleeping with the children the night of the infant's death. The UHM was aware of the risk of co-sleeping.

The Investigation Conclusion Narrative reflected ACS Sub the allegation of IG of the deceased infant by the UHM. However, in the Allegation Information list, ACS Unsub the allegation of IG of the deceased infant by the UMH.

As of 11/4/16, the case remains open for Court Ordered Services. The Association to Benefit Children was assigned case planning responsibility.

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
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:	Timely/Adequate 24 Hour Assessment
Summary:	The documentation reflected that the 24 Hour safety assessment for the 4/21/16 fatality investigation was not completed until 4/29/16. In addition, there were comments that did not support the selected safety factors.
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.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The Seven Day safety assessment for the 4/21/16 report was inadequate as there were comments that did not support the safety factors. ACS did not document how the mother's drug use negatively impacted her ability to care for the children.
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:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The Investigation Determination safety assessment of the 4/21/16 report was inadequate as there were comments that did not support the selected safety factors.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(b)
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:	Contact/Information From Reporting/Collateral Source
Summary:	The ACS case record did not reflect that EMS was contacted to obtain information about the time the 911 call was placed and observations of the home conditions.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
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:	Adequacy of case recording
Summary:	There were two reports registered on 4/21/16. ACS Sub the allegation of IG of the deceased infant by

	the UHM in one of the CPS Investigation Summaries and Unsub the allegation of IG of the deceased infant by the UHM in the other summary.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/21/2016 **Time of Death:** 06:00 AM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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: Not impaired.

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	Aunt/Uncle	No Role	Male	3 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	6 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	36 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Male	30 Year(s)

LDSS Response

ACS staff interviewed LE who said the SM began to reside with the MGM in January 2016. LE interviewed the UHM who said he went to sleep at about 3:00 AM and woke at about 5:00 AM. The SM said there was something wrong with the infant. The MGM checked the infant and told the UHM to call 911. The UHM was instructed to perform CPR, but the MGM administered the CPR to the infant. The infant was later pronounced dead at about 6:00 AM. The family of seven resided in a studio apartment.

On 4/21/16, the UHM said the MGM went to bed at about 12:30 AM. The MGM said the “girls” went to sleep at about 12:30 AM. She was awakened by the SM at 5:07 AM and the ambulance was called at 5:18 AM. The MGM said the infant’s lips were cold and there was white foam, and blood coming from the nose and mouth. EMS told the MGM to place the infant on the floor and perform CPR. The MGM admitted to marijuana use in the past. The MGM denied she misused drugs in the home. Later, she said for several months she had been instructing the SM to get a play pen or crib, and had offered to provide financial assistance. The MGM stated that this was the SM’s fault. She said the SM knew better than to sleep with the children and by her sleeping with them, she rolled onto the infant.

The UHM acknowledged he spent the night with the family but he denied he resided in the home. The UHM provided information about the position the mother and children slept in the bed. According the UHM, the order from left to right was the SM, 2-year-old, infant, and infant B. He said at 5:07 AM, the SM said there was something wrong with the infant. The MGM checked and saw the infant had blood and foam on her face. The MGM picked up the infant and told him to call 911. The operator instructed him to perform CPR and to lay her on a hard surface. The UHM then instructed the MGM on how to perform CPR as per the instructions from the operator.

The ME said there were no marks or bruising on the infant. Later, the ME said he was leaning towards the manner and cause of death to be Undetermined in relation to co-sleeping.

On 4/22/16, ACS interviewed Acacia Network (AN) Case Manager (CM). The CM began working with the family on 10/21/15. The last unit inspection prior to 4/21/16 occurred on 4/11/16. The CM said the MGM did not inform officials that the SM and children resided with her. The CM did not observe the SM and children and there was no sign or indication that they resided with the MGM. The MGM informed the CM that the infant passed away. The CM conducted a unit inspection and saw no signs of a long term stay. The CM said that to her knowledge the family was staying with the MGM for that one night. Later, the AN agency explained that it was unclear whether the SM temporarily resided in the shelter or had been spending the night.

On 4/23/16, ACS placed all of the children into protective custody. During a 4/25/16 conference, ACS discussed plans for filing an Article Ten Neglect petition on behalf of the surviving children. ACS planned to request services to address parenting, DV, clinical health evaluation and Early Intervention.

On 4/25/16, an Article Ten petition was filed and a remand was granted in Bronx County Family Court (BCFC). The MGM’s children were paroled to her with ACS supervision on 5/9/16. She returned to PATH for housing assistance. The SM’s children remained in foster care with New York Foundling (NYF). On 5/26/16, the BCFC found there was no

evidence that the SM had any responsibility for the death of the infant. The BCFC released the SM's children to her care.

The SCR registered a report on 5/25/16 with the allegation of IG of the 6-year-old MU by the MGM. ACS investigated the report and the agency Unsub the allegation of IG on the basis of lack of credible evidence.

On 5/28/16, the SM was referred for homemaking services. Later, a joint home visit occurred between ACS, Family Preservation Program (FPP), and Association to Benefit Children (ABC).

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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
031201 - Deceased Child, Female, 4 Mons	031202 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
031201 - Deceased Child, Female, 4 Mons	031203 - Grandparent, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
031201 - Deceased Child, Female, 4 Mons	031208 - Unrelated Home Member, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
031201 - Deceased Child, Female, 4 Mons	031203 - Grandparent, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
031201 - Deceased Child, Female, 4 Mons	031208 - Unrelated Home Member, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
031201 - Deceased Child, Female, 4 Mons	031202 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
031209 - Sibling, Male, 2 Year(s)	031203 - Grandparent, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
031209 - Sibling, Male, 2 Year(s)	031208 - Unrelated Home Member, Male, 30 Year(s)	Inadequate Guardianship	Substantiated

031209 - Sibling, Male, 2 Year(s)	031202 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
031210 - Sibling, Female, 4 Month(s)	031202 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
031210 - Sibling, Female, 4 Month(s)	031208 - Unrelated Home Member, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
031210 - Sibling, Female, 4 Month(s)	031203 - Grandparent, Female, 36 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	☐	☒	☐	☐
Pediatrician	☐	☐	☐	☒
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:

The documentation did not reflect that EMS was contacted to obtain information especially the time the 911 call was placed.

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:
On 4/23/16, ACS went to the home of the father for the 6-year-old MU to place him into protective custody. The surviving twin, 2-year-old child and 3-year-old MU were placed into protective custody on 4/23/16. On 4/25/16, the outcome of the child safety conference (CSC) was to file an Article Ten Neglect Petition requesting a remand of all the children. On 4/25/16, an Article Ten was filed in Bronx Family Court and a remand was granted.

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:**
04/25/2016	There was not a fact finding	There was not a disposition
Respondent:	031202 Mother Female 20 Year(s)	
Comments:	On 4/25/16, an Article Ten Neglect petition was filed naming the SM and MGM as the respondents. The children were remanded the same day. On 5/9/16, the 3-year-old and 6-year-old children (MUs) were paroled to the MGM under ACS supervision. The surviving twin and 2-year-old child remained in foster care. On 5/26/16, the Family Court found there was no evidence that the SM had any responsibility for the death of the infant. The Family Court did find it concerning that after the death of the infant, the SM left the two children with the MGM without providing the MGM with her contact information but believed that the circumstances did not rise to the level of imminent risk. The Family Court reasoned that the prior indicated case from 2015 for the SM and the twins testing positive for marijuana did not warrant a removal of the children. The Family Court found there was no evidence of any health symptomology that was relevant to her ability to care for the children. The judge released the children to the mother with the following conditions: comply with a clinical health evaluation and any recommendations, comply with a CASAC assessment, comply with intensive PPRS, comply with parenting skills, maintain stable housing, maintain adequate income, not to leave the subject children alone with an uncleared ACS resource and comply with ACS supervision and reasonable referrals.	

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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: Family Preservation Program (FPP)

Additional information, if necessary:
The SM accepted services through the Association to Benefit Children agency. The MGM had preventive services through the SCAN NY agency.

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 filed an Article Ten Neglect petition in Bronx County Family Court. A remand was granted for the SM and MGM's children. The children were placed with New York Foundling (NYF).

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS filed an Article Ten Neglect Petition in Bronx County Family Court. A remand was granted for the SM and MGM's children. The children were placed with New York Foundling (NYF).

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

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)
12/04/2015	11104 - Deceased Child, Female, 2 Days	11102 - Mother, Female, 19 Years	Inadequate Guardianship	Indicated	Yes
	11105 - Sibling, Female, 2 Days	11102 - Mother, Female, 19 Years	Inadequate Guardianship	Indicated	
	11105 - Sibling, Female, 2 Days	11102 - Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Indicated	
	11104 - Deceased Child, Female, 2 Days	11102 - Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Indicated	
	11106 - Sibling, Male, 1 Years	11103 - Father, Male, 20 Years	Inadequate Guardianship	Indicated	
	11106 - Sibling, Male, 1 Years	11102 - Mother, Female, 19 Years	Inadequate Guardianship	Indicated	

Report Summary:

The 12/4/15 report alleged the father exhibited aggressive and threatening behavior to the 1-year-old child. On 12/ 4/15, the father visited the mother and twin infants in the hospital. The father had the 1-year-old child strapped in a stroller and went to the bathroom. He left the stroller on the other side of the room away from the mother, who had a medical procedure and could not move well and was lying down. While he was in the bathroom, the child stood up in the stroller

causing the stroller to tip over. The child cried and father came out of the bathroom and yelled at the child. He grabbed the child very forcefully by the biceps and then threw him back into the stroller.

Determination: Indicated | **Date of Determination:** 02/02/2016

Basis for Determination:
Montgomery County DSS (MCDSS) observed the treatment the 1-year-old child received from his parents. On 12/4/15, MCDSS observed the father become frustrated by the child's behavior and lifted him by the bicep and attempted to place him in his stroller. MCDSS also observed the SM reach over the child at which time MCDSS saw the child flinch and cower. The SM denied she used marijuana during her pregnancy. The SM said she told her Dr. she was unable to keep food down early in her pregnancy and advised the Dr. she was used marijuana. As a result, the twins were born with a positive toxicology for marijuana. The parents had little to no supplies for the twin infants.

OCFS Review Results:
The MCDSS completed safety assessments on 12/10/15 and 12/21/15. The Seven Day safety assessment was completed in a timely manner. The documentation reflected the twins tested positive for marijuana and the SM did not. The parents denied drug use. The investigation did not reflect that MCDSS referred the mother for drug testing. The SM said the child was getting out of the stroller when the stroller fell over. The SF was in the bathroom. The SF said he went into the bathroom and the child stood up in his stroller. He denied forcefully picking up the child and throwing him into the stroller. MCDSS did not address whether the parents had safe sleep education.

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

Issue:
Failure to Offer Services

Summary:
During the 12/4/15 investigation, MCDSS did not assess the mother for drugs nor provide referral for a professional to evaluate her for drug use.

Legal Reference:
SSL 424(10); NYCRR 428.6

Action:
MCDDS 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. MCDDS 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)
11/18/2015	11081 - Aunt/Uncle, Male, 17 Years	11084 - Father, Male, 39 Years	Inadequate Guardianship	Unfounded	No
	11081 - Aunt/Uncle, Male, 17 Years	11083 - Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	11081 - Aunt/Uncle, Male, 17 Years	11085 - Grandparent, Female, 60 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 11/18/15 SCR report alleged that since 11/17/15 the 17-year-old child had been homeless. The parents as well as his legal guardian/grandmother were aware of the situation but did not plan for this child's care. The child could not stay with either of the above guardians because he did not feel safe in the respective home environment. Therefore, the child was in need of urgent intervention.

Determination: Unfounded | **Date of Determination:** 01/13/2016

Basis for Determination:
The basis for the determination was the child and was in the legal care and custody of the PGM. The grandmother's home was assessed to be safe and contained all the provisions needed for the child. The child, grandmother and biological parents all reported that the child was residing in the grandmother's home and was not homeless. It was reported that the child on occasions visits with his own child's mother and stays at her home overnight to be with his son. The child attended school on a regular and consistent basis and had done well so far in the school year. At this time, no information was obtained to suggest that the child was homeless or unsafe and all his basic needs seemed met.

OCFS Review Results:
ACS initiated the investigation within the required timeframe. ACS did not complete the Investigation Actions but completed safety assessments on 11/23/15 and 1/7/16. The Seven Day safety assessment was also completed on time. During the child's interview, he denied that he was homeless. He said he resided with his PGM. ACS established contact with the child's school and the subjects of the report. The child was a father himself but he did not provide information to ACS regarding the mother of his child.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/27/2014	11071 - Sibling, Male, 4 Months	11068 - Mother, Female, 18 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	11071 - Sibling, Male, 4 Months	11070 - Father, Male, 20 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	11071 - Sibling, Male, 4 Months	11068 - Mother, Female, 18 Years	Inadequate Guardianship	Unfounded	
	11071 - Sibling, Male, 4 Months	11070 - Father, Male, 20 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 6/27/14 SCR report alleged the parents had some cognitive and/or clinical health issues. The report also alleged the parents did not feed the 4-month-old infant on a regular basis. There was little to no food in the home and they were not bringing any in. The apartment had an odor emanating from it and there was garbage and debris throughout. The parents were sleeping alongside the infant even though a new crib was provided. The parents broke the crib. The parents smoked marijuana but there was no information available. The parents refused to follow shelter rules and were evicted several times.

Determination: Unfounded | **Date of Determination:** 08/26/2014

Basis for Determination:
ACS did not find evidence to substantiate the allegations and found there were adequate provisions for the infant.

OCFS Review Results:
ACS initiated the investigation within 24 hours. The safety assessments were completed on 7/3/14 and 8/21/14. The seven day safety assessment was completed on time. However, the associated comments did not support the selected safety factor. The safety factor for the 8/21/14 safety assessment did not support ACS' decision regarding the negative impact of the SM's ability to supervise, protect and/or care for the child. The ACS case record reflected the parents denied DV and drug use. ACS did not discuss safe sleep. The family was assigned to another shelter. ACS did not update the family's address in CONNECTIONS household composition.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The Seven Day safety assessment was completed on time. However, the comments that were documented did not support the selected safety factor.

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:
Predetermination/Assessment of Current Safety and Risk

Summary:
In the 8/21/14 safety assessment, ACS did not provide associated comments to justify the reason for selecting the safety factor that stated the SM's condition had a negative impact on her ability to supervise, protect and/or care for the child.

Legal Reference:
18 NYCRR 432.1(aa)

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)
12/04/2013	11036 - Aunt/Uncle, Male, 4 Years	11035 - Father, Male, 38 Years	Inadequate Guardianship	Indicated	No
	11036 - Aunt/Uncle, Male, 4 Years	11035 - Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:
The 12/4/13 SCR report alleged when the father and 4-year-old child's room was inspected, marijuana was found in the bed the father shared with his son. There was approximately one gram bag of marijuana, considered for personal use, in the bed. The child would have access to this bag of marijuana. It was unknown whether the father used or sold drugs.

Determination: Indicated | **Date of Determination:** 01/14/2014

Basis for Determination:
There was credible evidence to support a finding of maltreatment. The father drug tested twice for the drug PCP.

OCFS Review Results:
The investigation began on time. The Seven Day safety assessment was completed within the required time frame. The child was initially observed in his school. The father denied substance abuse. He said the bag of marijuana may have been left in the home by one of the friends who visited him in the shelter room. The father submitted to a drug test and it was positive for Phenycyclidine (PCP). ACS confirmed the father attended a program. The school staff said the child was discharged and transferred to a school out of New York state. The MGM had legal custody of the MU and he returned to her care out of New York state. A courtesy visit was requested but it was refused.

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

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

The URH was not known to the SCR or ACS. The SM was not known as a subject more than three years prior to the fatality.

The MGM was known as a subject in six reports dated 10/28/98, 5/8/09, 5/14/09, 2/20/10, 9/23/10, and 10/4/10. The allegations of the 10/28/98 report were IF/C/S and IG. The report was Sub on 12/29/98. The allegations of the 5/8/09 report were IG, Other, and IF/C/S by an adult and Other by the MGM. On 7/6/09, the allegations of IG and IF/C/S was Sub and Other was Unsub. The allegations of the 5/14/09 report were IG and PD/AM of the SM (who was a child at the time) and the now 6-year-old MU by the MGM and an adult, and IG and PD/AM of the SM and IG of the now 6-year-old MU by an another adult. On 7/13/09, the allegation of IG if the now 6-year-old MU by an another adult was Unsub; all other allegations were Sub. The allegations of the 2/20/10 report were IG and LS of the now 6-year-old MU and SM (who was a child) by the MGM. The report was Unsub on 4/22/10. The allegation of the 9/23/10 report was IG of the the now 6-year-old MU and SM (who was a child) by the MGM. On 1/6/11, the report was Sub. The allegations of the 10/5/10 report were IG and PD/AM by the MGM and an adult. On 1/6/11, the report was Sub.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Required Action(s)

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

Issue:	Adequacy of case recording
Summary:	MCDSS was informed that the SM took the three children with her to NYC and went to the MGM's apartment in a shelter located in the Bronx. There was no attempt by MCDSS to contact New York City Department of Homeless Services regarding the MGM.
Legal Reference:	18 NYCRR 428.5(c)
Action:	MCDDS 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. MCDDS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Preventive Services History

On 3/6/07, Family Court ordered a court ordered investigation (COI) as the PA petitioned for custody of the now 14-year-old. A final order of custody was granted 4/4/07. During the 6/27/14 investigation, ACS opened a FSS on 7/3/14 to provide PPRS as ACS believed there was a need for services. After the Specialist consultation; ACS gave the SM information regarding community based services and respite services for infants. The FSS was closed on 9/8/14.

Also, the FSS was opened on 10/31/14 due to a COI as the father of the now 6-year-old MU requested the Manhattan

County Family Court grant him an Order of Custody. The MGM took the MU from his care. The FSS was closed on 12/5/14; the petition was dismissed on the last court hearing.

During the 12/4/15 investigation, MCDSS opened a FSS on 12/15/15. The initial FASP reflected that MCDSS addressed the allegations with the SM and it was learned she did not have supplies for the twin infants. The twin infants were born with a positive toxicology. The SM and SF were willing to attend Community Maternity Service, Alpha Pregnancy to keep the children safe. The FSS was closed on 3/3/16. The FASP dated 3/2/16 reflected the SM left MC with her three children and was believed to be residing in NYC, perhaps with the MGM. Prior to leaving, the SM indicated she did not want voluntary preventive services to continue.

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