Child Fatality Report

Report Identification Number: NY-17-004

Prepared by: New York City Regional Office

Issue Date: Aug 14, 2017

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 01/15/2017
Initial Date OCFS Notified: 01/15/2017

Presenting Information

On 1/15/17, the SCR registered a report which alleged the BM placed the SC in his bassinet for a nap at 2:00PM, placed a blanket under his head, and closed the door to the room. The BM returned approximately an hour and a half later and found the SC with the blanket covering his face and tangled around his neck. The SC was blue, had purple lips, and the blanket was wet. The report alleged the BM called 911 and was instructed to place the child on the floor and perform chest compressions. The SC was transported by an EMS ambulance and arrived at the hospital at 4:27 PM and was pronounced dead at 5:31PM. The cause of death was cardiac arrest due to asphyxiation from the blanket in his bassinet. The SC was an otherwise healthy child. The BM was named as the subject of the report.

Executive Summary

The SC was three months old when he died on 1/15/17. The autopsy report had not been issued and the ME did not provide a preliminary cause and manner of death.

On 1/15/17, the SCR registered a report with the allegations DOA, LS, and IG of the SC by the mother. On 1/19/17, the SCR registered a second report with allegations L/B/W, S/D/S, and IG of the six-year-old surviving sibling by the father. The reports were consolidated.

The SC resided with the mother and three siblings in a two-bedroom apartment. The mother shared one bedroom with the six-year-old surviving sibling who slept on a mattress located on the floor by her bed and the SC slept in a bassinet. The other surviving siblings shared a room and slept in individual cribs.

ACS initiated the investigations within the required time frames. The home had no safety concerns and the surviving siblings were assessed to be safe in the care of their parents.

According to the case documentation, the mother indicated she fed the SC at 12:00 P.M., and at 2:00 P.M., she placed him on his back in his bassinet for a nap. The mother closed the door of the bedroom to keep the surviving siblings from disturbing the SC. The mother said that after leaving the SC in the bedroom she went to the kitchen to feed the three surviving siblings. The mother reported she returned two hours later to check the SC and found him lying on his side with yellow particles in his hand from the blanket used to support his head. The mother said the blanket was over the SC's face and when she removed it, the SC's face was purple. The mother said she immediately called 911 and administered CPR as instructed by the operator. EMS arrived at the case address and transported the SC to Brooklyn Hospital. Upon the SC's arrival at the hospital, resuscitation efforts continued to no avail, and he was pronounced dead at 5:31 P.M. The father who did not reside with the family left work to stay with the surviving siblings while the mother went to the hospital. There were discrepancies in the case documentation concerning the items the mother placed in the bassinet, but there was no clarification of these discrepancies.

Based on the surviving siblings' ages and special needs, they were unable to provide an account of the events leading to the SC's death.

The NYPD indicated they responded to a 911 call at 4:10 P.M. The NYPD conducted a scene investigation and found no suspicions or criminality in connection to the SC's death.

The staff at Brooklyn Hospital indicated EMS arrived at the hospital with the SC at 4:27 P.M. with a temperature of 102.8 degree Fahrenheit. The mother was unable to explain the SC's temperature. The medical staff at Brooklyn Hospital reported the SC had no external signs to suggest physical injuries.

On 1/18/17, ACS held a Child Safety Conference (CSC) and both parents were present. During the CSC, there were no safety issues identified concerning the surviving siblings. The conference focused on the events leading to the SC's death and services for the family. Although there were services in place for the surviving siblings, ACS determined court intervention was needed based on the allegation of LS of the SC. ACS did not identify specific LS concerning the surviving siblings or add any allegations concerning these children.

On 1/19/17, ACS filed an Article 10 Neglect Petition at the Kings County Family Court (KCFC) naming the mother as the respondent on behalf of the surviving siblings. Family Court granted Court Ordered Supervision of the family and a referral was made for preventive services.

The siblings' pediatrician indicated the mother had scheduled two appointments for the SC which she failed to keep. ACS determined the SC had not received medical care after his discharge from the hospital.

On 3/16/17, ACS substantiated the allegations of DOA, LS and IG of the SC by the mother. The allegations against the father were all unsubstantiated.

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?** No
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

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:
1. Although the level of casework activity was appropriate, the information gathered was not reflected in the investigation determination narrative.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	The safety decision was not consistent with the case documentation. The comments documented to support the safety factors were focused on the SC.
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 Performance Improvement 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 several discrepancies throughout the investigation which were not properly addressed.
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 fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Face-to-Face Interview (Subject/Family)
Summary:	Although the father was present during the investigation, very little was documented concerning his input or relevant information concerning the family and/or his role.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
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 Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriateness of allegation determination
Summary:	Based on the documentation, the narratives to support the determination were not consistent with the information gathered during the investigation.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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 Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Assessment as to need for Family Court Action
Summary:	The assessment for the need of COS for the siblings was not clear as the mother had all relevant services for the siblings in place and there was no concerns noted specific to risk and/or safety by collateral or service providers.
Legal Reference:	SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)
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 Performance Improvement Plan

	within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP did not include the father as a secondary caretaker. The documentation reflected the father was involved with the children and co-parenting although it was reported he did not reside in the home.
Legal Reference:	18 NYCRR 432.2(d)
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 Performance Improvement 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: 01/15/2017 **Time of Death:** 05:31 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 04:10 PM
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: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Father	No Role	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)

Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	6 Year(s)

LDSS Response

The SC was three-months old when he died on 1/15/17. The autopsy report has not been issued and the ME did not provide a preliminary cause and manner of death.

On 1/15/17, the SCR registered a report with allegations of DOA, LS and IG of the SC by the mother. On 1/19/17, the SCR registered a second report with allegations of L/B/W, S/D/S and IG of the six-year-old sibling by the father. The two reports were consolidated.

On 1/18/17 and 2/21/17, ACS held a CSC as required. There were no safety factors identified concerning the surviving siblings.

At the initial CSC, ACS reinterviewed the mother concerning the events leading to the SC's death.

ACS did not clarify the various accounts the mother reported concerning the items she placed in the bassinet. The mother's account of events that led to the SC's death was not consistent. The NYPD stated the mother reported she used a "kid's pajama" as a pillow and placed it in the bassinet. The medical staff at Brooklyn Hospital said the mother reported she placed a blanket on the bottom of the bassinet and folded the edge of the blanket to make a pillow to support the child's head. The mother reported she had not received any safe sleep education and ACS did not follow up with her response.

ACS documented the need for the mother to receive treatment for her medical condition, submit to a clinical evaluation and a random drug screening. The ICSC did not specify why these services were necessary or how these issues impacted the mother's ability to care for the surviving siblings. The results of the mother's drug screening were negative for all illicit substances.

Although the father was present, there was minimal documentation concerning the father's verbal participation in the interviews.

ACS contacted the siblings' pediatrician, home attendant, early intervention therapist, MGF, neighbors and the school where the six-year-old surviving sibling received special education services. None had any concerns about the parents' ability to care for the surviving siblings.

The surviving siblings' pediatrician had no concerns about the health of the mother's children, the pediatrician had not met the SC.

The ME indicated the SC's height and weight was appropriate; he, the SC was well-hydrated and there were no signs of trauma to his body. However, the ME did not provide the cause of death or an explanation for the SC's temperature of 102.8 degree Fahrenheit.

ACS substantiated the allegations against the mother citing she had not kept medical appointments for the SC. In addition, ACS cited the mother left the SC unattended for several hours; which was not consistent with the information gathered during the investigation. ACS' case documentation notes the mother reported she laid the SC for a nap at 2:00 P.M. and the 911 call was made at 4:10 P.M. which reveals the mother checked the SC about two hours later while she attended to the siblings.

NYCRO's review found ACS did not conduct a thorough investigation. The documentation in the safety and risk assessments, progress notes and/or investigation conclusion was not clear and concise; nor consistent with the case circumstances. The father was referred to as a "back up resource" and attempts to fully engage him were not evident.

ACS unsubstantiated the allegations against the father citing the sibling made no disclosure of abuse at the CAC and the father was "not responsible for the sibling's basic needs on a regular basis." ACS did not conduct thorough interviews with the father and did not consider his role as a parent when making assessments. Therefore, he was not considered in the completion of the risk assessment.

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 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
034841 - Deceased Child, Male, 3 Mons	034842 - Mother, Female, 32 Year(s)	Lack of Supervision	Substantiated
034841 - Deceased Child, Male, 3 Mons	034842 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
034841 - Deceased Child, Male, 3 Mons	034842 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
038743 - Sibling, Male, 6 Year(s)	034842 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
038743 - Sibling, Male, 6 Year(s)	034842 - Mother, Female, 32 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
038743 - Sibling, Male, 6 Year(s)	034842 - Mother, Female, 32 Year(s)	Swelling / Dislocations / Sprains	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?	☒	☐	☐	☐

Additional information:
Due to the ages of the surviving siblings and their special needs, they were not interviewed concerning the SC's death.

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?	☐	☐	☒	☐

Explain:
The 7-and 30-Day Safety Assessments noted there was immediate and impending danger of serious harm concerning the surviving children; however, neither the selected safety factors nor case documentation supported this decision. In addition, several safety factors focused more on the SC than the surviving siblings.

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The RAP did not include the father; therefore, half of the assessment was not completed. ACS responded yes to the question of the death of the SC as a result of abuse or maltreatment without the ME's determination of the cause and manner of death. In addition, the documentation did not reflect there was an assessment of the family's expenses. The family resided in a New York City Housing complex where they paid a small fraction of their reported income. In most of these complexes utilities are included. The mother also reported that the father provided some financial support. However, during the investigation, the mother requested a bed for the 6 year old sibling who was receiving SSI benefits. ACS provided the bed, but did not question why the mother could not purchase one for the child.

Placement Activities in Response to the Fatality Investigation

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

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: Prevetive Services							

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:
The surviving siblings were not in need of any immediate services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The parents were not in need of any immediate service.

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
☐ Had heavy alcohol use
☐ Smoked tobacco

☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ 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)
10/28/2016	Sibling, Male, 6 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 6 Years	Mother, Female, 32 Years	Educational Neglect	Unfounded	
	Sibling, Male, 6 Years	Father, Male, 35 Years	Educational Neglect	Unfounded	
	Sibling, Male, 6 Years	Father, Male, 35 Years	Inadequate Guardianship	Unfounded	

Report Summary:
At the time of this report, the BM had two additional children one was the SC.

The report stated the 6-year-old sibling had special needs and repeated kindergarten due to his poor attendance. The report alleged the parents were aware of the problem but made no arrangements to improve the child's attendance. The BM attributed the attendance to a debilitating condition which interfered with her ability to take the SC to school. The parents were separated and the BF was residing an hour away from the case address. After ACS' involvement the parents agreed the BF would take the sibling to school whenever the BM felt sick.

Determination: Unfounded | **Date of Determination:** 12/27/2016

Basis for Determination:
The allegations of EDNG and IG of the 6-year-old sibling by the parents were inappropriately unsubstantiated.

ACS unsubstantiated the allegations against the father without providing the basis for their decision. ACS had credible evidence to substantiate the allegation of EDNG against both parents because they failed to ensure the sibling attended school on a regular basis. ACS did not consider the information provided by the school which noted the school attendance issue was a pattern with the sibling who had special needs and failed educationally the previous school year due to poor attendance.

The parents reached a solution after the report was registered with the SCR.

OCFS Review Results:
ACS met with the family within the required time frame, assessed the home to be safe and the children safe in the care of the BM.

ACS made collateral contacts with the service providers focusing on the services provided to the children, but did to request an assessment about the BM's ability to care for the children as it related to her condition. ACS made not collaterals concerning the father as it appears they did not give any focus on the fact that he was also a subject of the report. The father was not listed as the second caretaker in the RAP, therefore neither the determination or the RAP was completed properly.

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

Issue:
Appropriateness of allegation determination

Summary:
ACS had credible evidence to substantiate the allegation of EDNG against both parents as they failed to ensure the sibling attended school on a regular basis. ACS did not consider the information provided by the school when making their determination. The parents addressed the attendance issue only after ACS' involvement initiated by the SCR report.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
ACS did not complete the RAP properly as the father was not listed as a secondary caretaker. Also, the documentation of the investigation did not reflect the questions in the RAP were addressed with the father. This did not allow for a full assessment of future risk, the family's functioning and/or circumstances.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS made collateral contacts with the service providers, but did request an assessment about the BM’s ability to care for the children as it related to her condition. ACS made no collaterals contacts concerning the BF who was a subject of the report. The 2013 report noted the PGPs were a support to the family; however they were not contacted in this investigation.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
ACS did not conduct a face to face interview with the father who was listed as a subject in this report. The allegations and the reason the BF left the home were not addressed/explored with the father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement 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:
ACS made relevant collateral contacts with the school, EI, and pediatrician, but did not address the mother's ability to care for the children as it related to her condition. There was a medical consultation, but there is no indication that ACS attempted to have the BM sign a HIPAA to gather information concerning the BM's treatment or her ability to care for the children.

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 NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/07/2013	Sibling, Male, 3 Years	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Unfounded	No
	Sibling, Male, 3 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Sibling, Male, 3 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 3 Years	Father, Male, 31 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The SCR registered a report alleging that the parents had old food scattered throughout the home. It was alleged that old food was accessible to the then 3-year-old sibling; placed him at risk of harm.

Determination: Unfounded | **Date of Determination:** 03/19/2013

Basis for Determination:
ACS unsubstantiated the allegations of IF/C/S and IG of the then 3 year-year-old siblings by the parents. ACS based their decision on the information provided by the services providers and observations which indicated that the SCC was receiving the necessary services and ha adequate provisions. The home was always observed to be clean.

OCFS Review Results:
ACS made contact with the family within the required time frame and assess the home to be safe and clean for the sibling. The reported concerns were not observed by ACS or other service providers. The visits revealed that the parents had adequate provisions for the sibling and the support of family members. ACS completed all risk and safety assessments appropriately.

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

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

The family had no known CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

The family had no known 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