Child Fatality Report

Report Identification Number: NY-17-030

Prepared by: New York City Regional Office

Issue Date: Oct 06, 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: 17 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 03/12/2017
Initial Date OCFS Notified: 03/20/2017

Presenting Information

The 3/20/17 report alleged that on 2/16/17, the 17 year-old SC was paroled home to the SM and step parent (SP) after being in FC. The conditions of the SC's release home were that the SM and SP would monitor the SC's clinical health and substance abuse, and report her missing should she run away. The SC ran away on 2/17/17 and the SM and SP failed to report her missing. On 3/12/17, the SC was found unresponsive by a friend, at the friend's home. The SC was pronounced dead at the scene from an apparent drug overdose.

Executive Summary

The 17-year-old female child (SC) died on 3/12/17. The autopsy listed the cause of death as acute Methadone and Alprazolam intoxication and the manner as an accident (substance abuse). A contributing cause was chronic Cocaine and Oxycodone abuse.

The allegations of the 3/20/17 report were DOA/Fatality, IG, and CD/A of the SC by the SM and SP.

At the time of the SC's death, there was an active case in the Kings County Family Court (KCFC) as an Article Ten petition was filed on 9/9/16. The KCFC had granted a remand of the SC and COS for the 12-year-old CH. The SC was released to the SM on 2/16/17 on the condition that she engage the SC in drug treatment and mental health services, monitor her whereabouts, and contact LE if the SC ran away.

ACS learned from LE that the SC was found face down on the bed at the home of a friend. She was cold to the touch which suggested a delay in calling authorities after her death. LE said the friend was interviewed, and her account kept changing. LE said the SM did not file a missing person’s report for the SC in 2017, although the SC had left the home without the parent’s knowledge.

The SM indicated that around 3/8/17, the SP told the SC that if she continues to use drugs she would be placed into a drug treatment program. The SC became upset, packed her clothing, and left the home.

ACS learned that the SC's paramour made arrangement for the SC to go to his friend's home to sleep for one night. The SC arrived at the friend's home during the day and slept for five hours. The SC left the friend's home between 7:00 PM-8:30 PM and returned between 12:30 AM-1:00 AM. The friend said that her father and brother were present when the SC was in the home. The SC's adult friend said she was unaware that the SC used drugs the night prior to 3/20/17. The SC slept on the friend's couch in her bedroom. The SC asked to sleep in the bed with her, and she permitted this. When the friend woke up she observed that the SC's face was on the pillow and her body was still. She touched her hand, found it was cold and then called 911 for assistance.

On 4/26/17, an adjournment in contemplation of dismissal (ACD)was presented to the family; the family declined.

The Seven Day safety assessment was inadequate as the comment did not support the selected safety factor. The comment reflected that on 3/10/17, the SC ran away from her home and her whereabouts were unknown.

On 5/19/17, ACS Sub the allegations of IG and CD/A as there was credible evidence to support the allegations. When the

SC ran away from home, neither the SM nor the SP called LE to file a missing person's report, they did not call ACS or call known friends of the SC to locate her. The SM knew the SC had substance abuse issues and complained that she continued to misuse substances whenever she was with her paramour, yet the SM failed to get the SC into substance abuse services to address this concern. The last time the SC left, SM and SP failed to call LE or file a missing person's report; even though they were aware that SC left the home and continued to abuse drugs.

The allegation of DOA/Fatality was Unsub due to lack of credible evidence. Per the ME's report, the SC passed away from an accidental overdose of Methadone and Xanax abuse. The contributing factors were due to long term drug abuse.

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?** 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:
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 24-Hour safety assessment was not completed in a timely manner as it was not completed until 3/23/17.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a PIP 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 was inadequate as the comment did not support the selected safety factor. The comment reflected that on 3/10/17, the SC ran away from her home and her whereabouts were unknown.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a PIP 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 documentation did not reflect that ER personnel and EMS were interviewed about their observation of the SC and case circumstances.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP 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: 03/12/2017 **Time of Death:** Unknown

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: Unknown
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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	Female	17 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	49 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Stepfather	Alleged Perpetrator	Male	43 Year(s)

LDSS Response

ACS learned the SP contacted the school about the SC's death and it was decided that the 12-year-old surviving child would receive counseling in the school. The SM was recommended to NYC Well program for additional counseling.

The SC's paramour said he was with the SC the night of 3/19/17, and at the time the SC wanted to obtain some Suboxne. He said he wanted himself and the SC to enter a program but the SC told him she did not want a program as she had a fear of being sexually assaulted. He said a counselor at Hope House sexually assaulted her. The paramour said he learned of the SC's death through a friend. Later, he said he was with the SC on 3/18/17 throughout the day. They were both asked to leave their respective homes and were on the street until approximately 10:00 PM when he walked the SC to his friend's home. That was the last time he saw the SC. He did not know who was in his friend's home at the time he left the SC. He denied he gave the SC drugs. He called the friend who said she found the SC on the bed. He learned the SC had drugs in her possession. He did not know how she obtained the drugs, but she had knowledge about how to obtain them.

On 3/20/17, the SM said the ACS Specialist did not file a missing person's report when the SC went missing or call for LE to visit the paramour's home. She said the 12-year-old CH and other family members would receive bereavement counseling. The SM informed ACS that she wanted nothing from ACS.

The SC's paramour's father said the SM and SC had been fighting about misuse of drugs and the plans for the SC to stop using drugs. The SC called her own contacts to obtain drugs; the SC ran away to a friend's home.

During a 3/23/17 conference, the SM said she stopped using drugs approximately 3 ½ years ago. The SM said she made several attempts to obtain help for the SC and all the places she contacted were not able to help the SC. The SM said she was referred to the JBFCS and she made an appointment. She said she would use the community based organization, and follow up with the school counseling for the 12-year-old CH. The SM was willing to submit to a drug screen. The documentation reflected that ACS contacted the drug testing facility on 4/5/17, and was informed by the facility the SM did not attend the drug screening.

On 4/4/17, the SM said that the SC's friend said the SC's paramour gave her three different drugs. The SM said the SC left the home after SP told the SC she was not allowed to bring drugs into the home and explained that they would find a drug treatment program for her. On 4/17/17, ACS offered the SM PPRS; however, the SM declined the offer. Later, ACS confirmed the SM had taken the CH to JBFCS for an intake appointment on 4/12/17.

On 5/18/17, the SP denied he had a fight with the SC the weekend prior to 3/20/17. The week that she passed he was in the kitchen with the 12-year-old CH, when the SC entered the kitchen and he observed that she cut herself. He told the SC she

would have to go into a hospital to get medical assistance to address her condition. The SC denied she was cutting herself. He was aware the SC misused drugs. He acknowledged he did not call LE as they contacted LE other times when she ran away and nothing happened. He said when she left, they contacted the SC's attorney.

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
040401 - Deceased Child, Female, 17 Yrs	040402 - Mother, Female, 49 Year(s)	Childs Drug / Alcohol Use	Substantiated
040401 - Deceased Child, Female, 17 Yrs	040403 - Stepfather, Male, 43 Year(s)	Inadequate Guardianship	Substantiated
040401 - Deceased Child, Female, 17 Yrs	040402 - Mother, Female, 49 Year(s)	Inadequate Guardianship	Substantiated
040401 - Deceased Child, Female, 17 Yrs	040402 - Mother, Female, 49 Year(s)	DOA / Fatality	Unsubstantiated
040401 - Deceased Child, Female, 17 Yrs	040403 - Stepfather, Male, 43 Year(s)	Childs Drug / Alcohol Use	Substantiated
040401 - Deceased Child, Female, 17 Yrs	040403 - Stepfather, Male, 43 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐

First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:
ACS documentation did not reflect that ACS performed a death scene investigation, contact EMS, and ER personnel.

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 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.

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: PPRS							
Additional information, if necessary: ACS referred the family for PPRS. The SM was referred for random drug screening on 4/21/17.							

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 SM notified the 12-year-old CH's school of the SC's death and made an agreement for bereavement services at school. The SM made an appointment for the 12-year-old CH with the JBFCS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM declined ACS offer for PPRS.

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?	Yes
Was the child ever placed outside of the home prior to the death?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/07/2016	Deceased Child, Female, 16 Years	Stepfather, Male, 43 Years	Inadequate Guardianship	Unfounded	Yes
	Deceased Child, Female, 16 Years	Mother, Female, 48 Years	Inadequate Guardianship	Indicated	
Report Summary: The 8/7/16 report alleged that the SC had mental health issues, specifically depression, for which she was being treated. The SM gave the SC her bottle of prescribed medication so that the SC could learn responsibility. The SC felt the					

medication was not working, so she took double the amount. On 8/5/16, the SP locked the SC out of the home.

Determination: Indicated | **Date of Determination:** 10/05/2016

Basis for Determination:
The SP was not legally responsible for the SC and had made reasonable efforts to assist her when necessary. There was a lack of evidence to support the allegation. On 8/7/16, the SC was hospitalized and discharged on 8/15/16 with a recommendation for medication, therapy and services. She had refused to engage in any services or comply with medication treatment. The next morning the SC left the home to be with her 25-year-old paramour; the SM contacted LE and on 8/19/16 the SC returned home. The SC became out of control and was transported to the ER by LE and EMS. The SC disclosed to ACS that she purchased Xanax off the street. She also tested positive for Suboxone.

OCFS Review Results:
ACS noted that the SC, SM and SP provided conflicting reports. The SM said she contacted LE about the relationship the SC had with a 25-year-old paramour; however, ACS did not verify whether the SM contacted LE about the issue.

During an 8/19/16 meeting the SM said the SC left the home, and SM filed a police report. When the SC returned home her condition had deteriorated and she was taken to the hospital. A PA agreed to care for her, but she left the PA's home, returned in an intoxicated condition and was again taken to the hospital. The SM had refused to take the SC home with prescribed out-patient services; an Article Ten Petition was filed and a remand granted for SC on 9/9/16.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
During the investigation, the SM said she contacted LE about the relationship the SC had with her 25-year-old paramour. However, ACS did not confirm with LE whether the SM contacted them pertaining to the matter.

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

Action:
ACS must submit a PIP 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/Supervisor Review

Summary:
The Investigation Conclusion Narrative dated 8/7/16 did not address whether the SM gave the SC her bottle of prescribed medication so the SC could learn responsibility, and the statement that the SC alleged used double the prescribed dosage.

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

Action:
ACS must submit a PIP 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:
Case record contains information that relevant, useful, factual and objective

Summary:
The Investigation Conclusion Narrative reflected that the SP was not legally responsible for the SC and had made reasonable efforts to assist her when necessary. During the SP's interview on 8/8/16, he said that he took care of the SM's children as if they were his own. ACS did not appropriately apply the definition of the term person legally responsible.

Legal Reference:

18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:

ACS must submit a PIP 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)
09/24/2014	Sibling, Male, 10 Years	Father, Male, 45 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Male, 10 Years	Father, Male, 45 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:

The 9/24/14 report alleged that on 9/23/14, at approximately 8:59 PM, the father of the CH (then ten years old) was arrested for driving while intoxicated with the CH in the vehicle. The SM was not present and her role was unknown.

Determination: Indicated **Date of Determination:** 11/23/2014

Basis for Determination:

According to the Suffolk County Police Department this father was involved in a "hit and run" car accident and was later found to be under the influence of alcohol. The CH said he was frightened and uncomfortable after driving in the car with his father who seemed intoxicated and drove erratically, later hitting another moving car. The CH confirmed that his father was later apprehended by LE. The CH's emotional, mental, and physical condition was negatively affected by the father's misuse of alcohol and his loss of self control. The father failed to exercise a minimum degree of care.

OCFS Review Results:

According to the case record, the CH said his father picked him up after school. The father told him they were going to visit his paramour. The CH got into the backseat of the car and put on his seat belt. He smelled liquor on his father. While driving, his father hit the back of a car and both airbags deployed. The car was filled with smoke. He told his father to stop the car, but he continued driving until they arrived at the paramour's home. The CH said he had bruised sides due to the seat belts impact. The father did not discuss the 9/24/14 incident with the Suffolk County Child Protective Services. ACS did not obtain relevant information from pertinent collateral contacts.

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

There was LE involvement in the case circumstance; however, ACS documentation did not reflect LE was interviewed.

Legal Reference:

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

Action:

ACS must submit a PIP 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:

Overall Completeness and Adequacy of Investigation

Summary:

During a 9/24/14 interview, ACS learned that at about 7:00 PM the subject father told the CH that they were going to visit his paramour. ACS did not address with the CH whether he was at his father's home or the SM's home.

Legal Reference:

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

Action:
ACS must submit a PIP 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)
04/14/2014	Sibling, Male, 9 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 9 Years	Mother, Female, 45 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Deceased Child, Female, 14 Years	Mother, Female, 45 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 17 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 17 Years	Other - Parent Substitute, Male, 46 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 9 Years	Mother, Female, 45 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Deceased Child, Female, 14 Years	Mother, Female, 45 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Deceased Child, Female, 14 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 17 Years	Mother, Female, 45 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Deceased Child, Female, 14 Years	Other - Parent Substitute, Male, 46 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 9 Years	Other - Parent Substitute, Male, 46 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 17 Years	Mother, Female, 45 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:
The 4/14/14 report alleged that the SM abused prescription medication and sold her Food Stamps for money to purchase drugs. As a result, the children ages 7, 14, and 16 had gone without food. There had been instances where the electricity and gas had been shut off. The SM had recently moved the parent substitute, who was a drug addict, into the home after only knowing him for a short period of time.

Determination: Unfounded | **Date of Determination:** 06/10/2014

Basis for Determination:
ACS unsubstantiated the allegations as the SM submitted to a drug screening and the test result was negative. ACS visited the home and during every visit there had been lights on in the home. ACS interviewed the CP and confirmed that the home always had lights on when the CP attended the home visits. During every visit to the home there had been food and the SM had been cooking meals for the family. The day the report was registered the family recently purchased food and the subject children said they always had food.

OCFS Review Results:
The SM stated she kept all of her bills current and had never been in the home without lights or gas. She denied drug misuse. The SM acknowledged she used medication that was prescribed by her Dr. The family was under COS due to the SM's history of drug and alcohol misuse and the impact on supervision of the CH, who was then nine years old. The

family had continued to participate in PPRS. During the 4/15/14 visit, the family had adequate food and the home conditions were satisfactory. The sibling, SC and 9-year-old CH denied the allegations of the 4/14/14 report. The PPRS agency said the family was seen once every two weeks. The SM's paramour did not reside in the home.

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

Issue:
Pre-Determination/Supervisor Review
Summary:
The Investigation Conclusion Narrative was inappropriately completed as the allegation of IG of the three children by the PS was not addressed.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
Action:
ACS must submit a PIP 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 4/18/14 safety assessment was inadequate as the associated comments did not support the selected safety factor that stated the caretakers used illicit drugs or misused prescription medication to the extent that there was a negative impact on their ability to supervise, protect and/or care for the CHN.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must submit a PIP 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 6/10/14 safety assessment was inadequate as the associated comments did not support the selected safety factor that stated the caretakers used illicit drugs or misused prescription medication to the extent that there was a negative impact on their ability to supervise, protect and/or care for the CHN.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
ACS must submit a PIP 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:
Face-to-Face Interview (Subject/Family)
Summary:
During the investigation, ACS did not interview the PS who was a subject of the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:

ACS must submit a PIP 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 SM had a prescription medication; however, the documentation did not reflect that the Dr. was contacted regarding the SM.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a PIP 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.

[redacted]

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

The SM was known as a subject to the SCR and ACS in 15 reports between 4/13/07 and 5/30/13. Eight of the 15 reports were IND and 7 UNF. The SP was not known as a subject more than three years prior to the fatality.

The 15 reports included the allegations of IG, L/B/W, PD/AM, LS, SA, IF/C/S, B/S, and CD/A. ACS IND the reports dated 4/13/07, 8/26/09, 8/31/09, 2/28/10, 2/21/12, 4/11/13, and two reports on 5/30/13. ACS UNF the reports dated 9/2/07, 12/18/07, 1/15/08, 5/20/09, 1/6/10, 2/17/11, and 10/30/11.

Two reports were registered on 5/30/13 with allegations of IG and PD/AM; one report included the allegation of CD/A.

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: 08/22/2016

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: 08/22/2016

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?	☒	☐	☐	☐

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 not approved until 6/1/17 despite the 4/7/17 due date.				
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: ACS filed an Article Ten Neglect petition in KCFC on 9/9/16. The KCFC granted a remand of the SC and court ordered supervision for the 12-year-old CH.				

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 not approved until 6/1/17 although the due date was 4/7/17. The FASPs of 10/9/16 and 12/8/16 were not completed timely as they were not completed until 10/26/16 and 1/20/17 respectively.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must submit a PIP 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 face-to-face contacts with the child and/or childs parents or guardians
Summary:	The documentation reflected that there was no case activity in December 2016. ACS did not conduct a home visit between 11/29/16 and 1/17/17.
Legal Reference:	432.1 (o)
Action:	ACS must submit a PIP 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 in FASP
Summary:	The 4/7/17 FASP was inadequate as it did not include summary of family update-case update. There was no review of impact of services, key family events, and casework activities since the FASP that was completed on 1/20/17.
Legal Reference:	18 NYCRR 428.6(a)
Action:	ACS must submit a PIP 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

During the 4/13/07 investigation, ACS opened a Family Service Stage (FSS) on 4/27/07. The SM agreed to accept preventive services including parenting skills and family counseling. The HeartShare Human Services of NY was assigned case planning responsibility. The 1/13/09 FASP reflected that the goals of improving sibling relations, children respecting the SM, processing the experience of seeing and being involved in DV and improving the SM's self-esteem were not achieved as the family did not attend counseling sessions. The FSS was closed on 2/5/09.

During the 8/26/09 investigation, ACS opened an FSS on 10/23/09, and referred the family for PPRS after ACS found the SM had abused her prescribed medication and drank alcohol, leaving the children unsupervised and the PS used drugs in front of the children. The Jewish Child Care Association (JCCA) agency had case planning responsibility. The 8/9/10 FASP reflected the SM requested the case be closed as she felt her family was stable. She agreed to random drug screens during treatment, and all test results were negative. She continued prescribed medication management. The FSS was closed on 8/16/10.

During the 4/11/13 investigation, ACS filed an Article Ten Neglect petition on 6/3/13 for substance abuse allegation. ACS opened an FSS on 4/26/13. The case was closed 7/17/14 as the SM and family did not agree to enroll in services.

Required Action(s)

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

Foster Care Placement History

During the 8/7/16 investigation, ACS filed an Article Ten Neglect petition in the KCFC on 9/9/16. The KCFC granted a remand of the SC and court order supervision for the 12-year-old CH. At the time of the petition's filing, the SC was admitted to the hospital for treatment of her substance abuse and mental health condition. The SC was absent without leave (AWOL) from the ACS Children's Center (ACC) on 9/10/16. A missing person's report (MPR) was filed. The SC was picked up by LE and returned to the ACC where she was AWOL and an MPR was filed. ACS learned that the SC had been observed in a public location and taken to the hospital. During the hospital stay it was recommended the SC be placed in an in-patient rehabilitation facility with Arms Acres. The staff at Arms Acres recommended the SC receive in-patient services at Hope House.

ACS documentation showed that the SC finished the program at Arms Acres and was transferred to Hope House. The SC

requested discharge from Hope House; therefore, on 1/30/17, ACS picked up the SC from Hope House, then the SC was AWOL in status and an MPR was filed. On 2/16/17, the KCFC released the SC to the mother's custody. On 3/13/17, ACS learned that the SC was found unresponsive on 3/12/17 at a friend's home. The friend admitted they were with the SC's paramour and they misused drugs over the weekend.

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:**
09/09/2016	There was not a fact finding	There was not a disposition
Respondent:	040402 Mother Female 49 Year(s)	
Comments:	On 9/9/16, ACS filed an Article Ten Neglect petition in Family Court. A remand of the SC was granted and the 12-year-old CH was released to the care of the SM with ACS supervision.	

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