Child Fatality Report

Report Identification Number: NY-17-143

Prepared by: New York City Regional Office

Issue Date: Jun 14, 2018

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	OA-Other Adult	
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
CPS-Child Protective Services		
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
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 10 day(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 12/18/2017
Initial Date OCFS Notified: 12/18/2017

Presenting Information

The 12/18/17 report alleged that on 12/17/17, the SM and SF gave the SC two ounces of milk at 10:00 PM and then put the SC to bed. When they went to check the SC 15 minutes later, the SC was unresponsive. The SC was found sitting in his car seat, which was in his crib. The SF called 911 and then was instructed to perform CPR on the SC on a flat surface. EMS arrived and transported the SC to the hospital. CPR was performed for 45 minutes. The SC was pronounced dead at the hospital. The exact time of death was not known. Upon examination the SC had blood coming out of his nose and anus. There was no explanation for the SC's bleeding. The SC was an otherwise healthy CH which made his death suspicious. The cause of death was unknown.

Executive Summary

The 10-day-old male child (SC) died on 12/18/17. As of 6/14/18, NYCRO had not received a copy of the autopsy report.

The allegations of the 12/18/17 report were DOA/Fatality and IG of the SC by the parents. The SC had five siblings who resided with him.

Prior to the SC's death, an Article Ten Neglect petition was filed in the Queens County Family Court (QCFC) naming the parents as the respondents on 1/30/17. The five SSs were released to the care of the parents with court ordered supervision and mandated services for the parents. Later, the SM gave birth to the SC. An Article Ten Neglect petition was filed for the SC on 12/12/17, due to derivative neglect.

The parents provided different accounts of the incident that occurred on 12/17/17. The SM said between 8:30 PM-9:00 PM, she fed the SC and put him down on his back in his pack and play. The SM said she observed him about 15 minutes later. The SM saw his lips were blue. The SF was alerted and he administered CPR for about 15-20 minutes; she said she called 911. The SC was transported to the hospital where he was pronounced dead. SM remained in the home with the CHN and the SF went to the hospital. ACS observed the pack and play which was secured in the closet. The SM said she had not used marijuana in one year and was attending services at a community based organization (CBO). SM denied there was DV in the parents' relationship.

The SF said he and the SM prepared the CHN for bed around 9:00 PM. At about 10:00 PM, the SC was fed. He observed the SC 5 minutes later and he was fine. When he observed the SC 10-15 minutes later, he discovered that the SC was not breathing. He began “compression” to the SC’s heart. He said he gave the SC CPR while the SC was in the car seat. When he spoke with the 911 operator, he was told the SC needed to be placed on a flat surface. He put the SC on a coffee table and performed CPR for about 2-3 minutes before LE arrived. The SF said he had not used marijuana since January 2017. The SF was not in a drug Tx program. ACS documented that the CHN were observed to not have adequate sleeping arrangements. The parents indicated they were waiting for the agency to order beds. The family had moved into the apartment on 12/15/17.

On 12/19/17, LE said the preliminary report concluded there was no foul play involved. The preliminary report stated there was no bruising found. LE said it seemed to be an accident and no action would be taken.

On 12/20/17, a child safety conference occurred. The outcome was that the court ordered supervision was expected to continue until 7/12/18. The Bronx Works agency would provide bereavement: trauma based therapy; ongoing substance

abuse screening, Certified Alcohol and Substance Abuse Counselor (CASAC), homemaking, educational/vocational; explore burial fund, and Early Intervention for the 1-yo CH.

The 24-Hour safety assessment and 24-Hour Child Fatality Summary Report were not completed in a timely manner as these documents were not completed until 12/22/17. The 30-Day Child Fatality Summary Report was not completed in a timely manner as it was not completed until 1/24/18. The 2/12/18 safety assessment was inadequate as ACS included comments that did not support the selected safety factors.

On 2/16/18, ACS Unsub the allegations of DOA/Fatality and IG. ACS based the determination on the lack of evidence to verify that either or both parents were responsible for the SC's death. LE related that there was no evidence of foul play by the parents and the ME had determined a similar conclusion. The case was closed with no further LE involvement. LE described the incident as an accident. The cause and manner or death was unknown. The attending Dr. confirmed the SC was brought to the hospital unresponsive, but the SC was free of external injuries, deformities, no and marks/bruises were observed.

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?** No, sufficient information was not gathered to determine any of the 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 24-Hour safety assessment was not completed in a timely manner as it was not completed until 12/22/17.
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:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-Hour Child Fatality Summary Report was not completed in a timely manner as it was not completed until 12/22/17.
Legal Reference:	CPS Program Manual, Chapter 6, K-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.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day Child Fatality Summary Report was not completed in a timely manner as it was not completed until 1/24/18.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
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 2/12/18 safety assessment was inadequate as there were comments that did not support the selected safety factors. The comment regarding the SM's clinical health did not reflect whether the SM's actions had a negative impact on the CHN's care.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/18/2017 **Time of Death:** 12:14 AM

Date of fatal incident, if different than date of death: 12/17/2017
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 11:16 PM
Did EMS 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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	10 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	33 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)

LDSS Response

ACS interviewed the social worker (SW) at the hospital. ACS learned that the SF fed the SC at 10:00 PM and then put him to sleep. The SF observed the SC every couple of minutes, and after about 15 minutes he saw the SC was unresponsive. When 911 was called, the SF was told to remove the SC from the car seat and place him on a flat surface. The car seat was inside of the play pen. The attending Dr. provided a similar account. The Dr. said the SC bled from the nose, mouth and anus. The bleeding from the nose and mouth could be from the SF administering CPR, but bleeding from the anus was questionable. The Dr. said it was difficult to make a final finding until after the autopsy was completed.

On 12/18/17, the SM said that at about 8:45 PM, she fed the SC and put him down on his back in his pack and play. The SM observed him about 15 minutes later and saw that his lips were blue. The SF was alerted and he tried to administer

CPR; she said she called 911. The SC was transported to the hospital where he was pronounced dead. The SF said he and the SM prepared the CHN for bed around 9:00 PM. At about 10:00 PM, the SC was fed. He checked the CH five minutes later and there was no concern noted. When he checked the SC 10-15 minutes later, the SC was not breathing. He said he gave the SC CPR while he was in the car seat. He was told by the 911 operator the SC needed to be placed on a flat surface. He put the SC on a coffee table and performed CPR before LE arrived.

Later, ACS again interviewed the parents. The SM said she was not sure of the specific time for each event. The SM said that at about 8:15 PM, she fed and changed his diaper, and put him in the playpen. She checked him five minutes later and his lips were blue. SM alerted the SF who came into the bedroom and took the SC out of the playpen and put him on the bed. She called 911 and they instructed the SF on how to perform CPR. The SF reenacted the events for ACS. He said at about 10:00 PM, the SM fed the SC and placed him in the car seat, inside the pack and play. SF said that about 15 minutes later the SM checked on the SC. The SM picked up the SC and handed him to the SF who saw that the SC's lips were blue. He begun CPR and told the SM to call 911. The SF said the other CHN were in the living room preparing for bed. The parents stated they practiced safe sleep.

On 12/18/17, the CHN were interviewed at the ACS office. The 8-yo CH said he was in the living room sleeping with his siblings. The SF brought the SC into the living room and put him on the table. The CH said he did not know what occurred. The CH said he was on the phone with 911 and then LE arrived. The 12-yo CH said he heard the SM scream. He went to the bedroom where the SM, SF and SC were located, and the SF told the SM to call 911. The SF did not want them to enter the room.

On 12/18/17, the Bronx Works agency said the family was cooperative, they allowed access to the home, and they had positive interactions with the CP. There were no noted concerns. SM received services through a CBO, but due to her high-risk pregnancy, she decreased her attendance.

On 1/30/18, the CP reported that the bereavement counseling trauma based therapy was provided by the Bronx Works agency. The CHN received bereavement counseling in their respective schools except for the 12-yo CH who was awaiting the service through the Department of Education. Homemaking service had been implemented since 1/3/18. The CP said the SM stated the family was still grieving and she was not ready to resume services with the CBO.

On 2/12/18, the homemaking staff expressed having no concerns regarding the family.

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
045985 - Deceased Child, Male, 10 Days	045987 - Father, Male, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
045985 - Deceased Child, Male, 10 Days	045987 - Father, Male, 33 Year(s)	DOA / Fatality	Unsubstantiated
045985 - Deceased Child, Male, 10 Days	045986 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
045985 - Deceased Child, Male, 10 Days	045986 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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 12/18/17 fatality investigation did not reflect maternal or paternal relatives were interviewed. The documentation reflected that the CP would be working with the SM to obtain a medical provider for the CHN.

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

Additional information, if necessary:
Prior to the fatality, the SM was engaged at a CBO. During her pregnancy she decreased her attendance; however, the SM discussed her interest in another CBO program in her vicinity. The SF was referred for a Certified Alcohol Substance Abuse Counselor (CASAC) appointment.

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 CHN received bereavement counseling in their respective schools, except for the 12-yo CH who was awaiting the service through the Department of Education.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family received homemaking services and 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?	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)
01/25/2017	Sibling, Male, 11 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Male, 2 Months	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 7 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 1 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 5 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 11 Years	Father, Male, 33 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 2 Months	Father, Male, 33 Years	Inadequate Guardianship	Indicated	

Sibling, Male, 2 Months	Father, Male, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 7 Years	Father, Male, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 1 Years	Father, Male, 33 Years	Inadequate Guardianship	Indicated
Sibling, Female, 5 Years	Father, Male, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 11 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Male, 7 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Male, 1 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated
Sibling, Female, 5 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated
Sibling, Male, 11 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 2 Months	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 7 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 1 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 11 Years	Father, Male, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 7 Years	Father, Male, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 1 Years	Father, Male, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 5 Years	Father, Male, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 11 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated
Sibling, Male, 2 Months	Mother, Female, 33 Years	Lack of Supervision	Indicated
Sibling, Male, 7 Years	Mother, Female, 33 Years	Lack of Supervision	Indicated
Sibling, Male, 1 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Female, 5 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Indicated
Sibling, Male, 2 Months	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Indicated

Report Summary:
The 1/25/17 report alleged that the CHN (approximate ages: 11, 9, 4, and two CHN ages unknown) resided with the SM

and an unrelated male household member. The report also alleged that the SM smoked marijuana and smoking marijuana was a priority for the SM. The SM spent her money on marijuana and as a result the CHN's needs were unmet. The CHN were not adequately fed. The CHN had poor hygiene, were dirty and unkempt, and they were dressed in dirty clothing. The marijuana in the home was accessible to the CHN. The SM left the CHN home alone and unsupervised for periods of time up to about 10-25 minutes. The CHN were not mature enough to handle the responsibility.

Determination: Indicated | **Date of Determination:** 02/15/2017

Basis for Determination:
ACS did not include the basis for the determination in the Investigation Conclusion Narrative. ACS only summarized the case circumstances in the Investigation Conclusion Narrative.

OCFS Review Results:
On 1/25/17, ACS visited the home; the family resided in a shelter. The CHN were clean and they wore appropriate clothing. The SF and SM denied the allegations of the report. He denied he left the CHN in the room alone. The SF admitted he and the SM used marijuana. He did not smoke marijuana in the room or leave marijuana in the room. He said the SM periodically used marijuana and stopped using marijuana a week ago. SM said she did not use any drugs. All the CHN's clothing was lost in the flood at another shelter and they were not replaced. On 1/30/17, ACS filed an Article Ten Neglect petition.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-day safety assessment was inadequate as ACS included comments that did not support the selected safety factors. The comment regarding the SM's clinical health did not reflect whether the SM's actions had a negative impact on the care she provided to the SS's.

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 2/14/17 safety assessment was inadequate as it included comments that did not support the selected safety factors. The comments regarding the SM's clinical health and the parents drug use did not reflect whether the SM's actions had a negative impact on the care she provided the SS's.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/26/2016	Sibling, Male, 7 Years	Mother, Female, 33 Years	Educational Neglect	Indicated	Yes

Sibling, Male, 9 Years	Mother, Female, 33 Years	Educational Neglect	Indicated
Sibling, Male, 11 Years	Father, Male, 32 Years	Educational Neglect	Indicated
Sibling, Male, 9 Years	Father, Male, 32 Years	Educational Neglect	Indicated
Sibling, Female, 5 Years	Father, Male, 32 Years	Educational Neglect	Indicated
Sibling, Male, 7 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Female, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 8 Months	Father, Male, 32 Years	Inadequate Guardianship	Indicated
Sibling, Female, 5 Years	Father, Male, 32 Years	Inadequate Guardianship	Indicated
Sibling, Male, 8 Months	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 9 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 7 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 5 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 8 Months	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 9 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 11 Years	Mother, Female, 33 Years	Educational Neglect	Indicated
Sibling, Female, 5 Years	Mother, Female, 33 Years	Educational Neglect	Indicated
Sibling, Male, 7 Years	Father, Male, 32 Years	Educational Neglect	Indicated
Sibling, Male, 8 Months	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 9 Years	Mother, Female, 33 Years	Inadequate Guardianship	Indicated
Sibling, Male, 9 Years	Father, Male, 32 Years	Inadequate Guardianship	Indicated
Sibling, Male, 7 Years	Father, Male, 32 Years	Inadequate Guardianship	Indicated
Sibling, Male, 11 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Male, 7 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated
Sibling, Female, 5 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Indicated

Report Summary:
The 10/26/16 report alleged that the SM had clinical health problems which impeded her ability to provide adequate care for the 10-yo, 8-month-old, 9-yo, and unknown CH. The SF was aware of this and continued to leave the SM alone to care for the CHN. On 10/23/16, the SM drank to intoxication and became out of control with the CHN present. The SM fought with many of the adults. The SM almost dropped the 8-month-old CH when she was fighting with another adult. The SF was not present for this incident.

Determination: Indicated | **Date of Determination:** 12/19/2016

Basis for Determination:
The CHN had ongoing absences in school which were impacting their education. The parents misused marijuana and alcohol, and were unwilling to comply with services. The CHN had not seen the Dr. for over one year. The home conditions were deplorable and the parents were not willing to clean it.

OCFS Review Results:
ACS interviewed the CHN, BF and BM and obtained relevant informant. On 11/4/16, the SF said the SM's GM passed away and the SM attended the funeral. He did not attend the funeral with the SM and CHN because he went to work. He said the SM told him family members attacked her. On 11/10/16, the SM admitted that the incident had occurred. She said she was did not instigate the incident as the fight began when her family members attacked her. She denied she was intoxicated. On 12/15/16, ACS sought a legal consult and determined the family needed Family Preservation Program services to address the BM's drug misuse, CHN's education, developmental, housing and well-being needs.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 10/31/16 safety assessment was inadequate as there was a comment that did not support the selected safety factor. In the comment that stated the SM was reported to have a clinical health diagnosis, ACS did not state whether the SM's actions had a negative impact on the care she provided to 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:
Contact/Information From Reporting/Collateral Source

Summary:
ACS did not make diligent efforts to obtain information from the relevant collateral or family member contacts regarding the incident at the funeral. ACS did not interview the funeral establishment.

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:
Failure to Provide Notice of Indication

Summary:
The case record did not reflect that ACS provided the Notice of Indication for the parents who were the subjects of the report.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
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

Between 8/14/07 and 2/6/13, the SM and SF were listed as alleged subjects in four reports dated: 8/14/07, 10/26/11, 5/3/12, and 2/6/13. Three of the four reports were IND. The allegations of these reports were: LMC, M/FTTH, IF/C/S, IG, PD/AM, and EdN. The 10/26/11 report was UNF. The SM was listed as an alleged subject in a report dated 4/22/10. The allegations of the report were PD/AM, IG and IF/C/S; the report was UNF.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 12/19/2016

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: 12/19/2016

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?	☒	☐	☐	☐
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:
A preventive services case was opened on 12/19/16. The parents were willing to accept the Family Preservation Program (FPP) and PPRS.

Required Action(s)

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

Issue:	Adequacy of Progress Notes
Summary:	The ACS Family Service Progress Notes reflected that the home visits of 5/11/17, 5/24/17, and 6/16/17 were not documented appropriately as there were no details provided for these visits.
Legal Reference:	18 NYCRR 428.5
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:	Failure to Monitor
Summary:	ACS documentation reflected that during the month of July 2017, ACS did not establish contact with the family. Between 6/17/17 and 7/31/17, ACS did not establish contact with the family.
Legal Reference:	18 NYCRR 432.2(b)(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:	Timeliness of completion of FASP
Summary:	The case record reflected the 7/17/17 FASP was not approved until 7/23/17 by Bronx Works.
Legal Reference:	18 NYCRR428.3(f)
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 8/14/07 investigation, ACS referred the family for PPRS through the Puerto Rican Family Institute agency. ACS closed the case on 7/30/09.

During the 5/3/12 investigation, ACS opened a service case on 6/13/12 as the parents had not ensured the two CHN attended school on a consistent basis. The family was referred to the Safe Space agency and received educational support focused on the need for both parents to understand the importance of education and for the parents to work more closely with school staff. The CP provided parenting sessions with both parents regarding specific concerns. Another service provider assisted the family with housing. The case was closed on 8/29/13.

ACS opened a service case on 12/19/16 to address the BM's alcohol misuse and her involvement in an abusive or threatening incident with family members. The CHN had observed the incident and were endangered by the SM's actions. The SM had prior clinical issues that needed to be addressed. The CHN had poor attendance in school. The home was unkempt. The parents accepted services. An Article Ten Neglect petition was filed in Family Court on 1/30/17 due to ongoing neglect. The Family Court granted court ordered supervision stipulating that the parents comply with drug treatment, clinical health and other services. The family was referred to the Bronx Works agency.

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:**
01/30/2017	There was not a fact finding	There was not a disposition
Respondent:	045986 Mother Female 34 Year(s)	
Comments:	The SC had five siblings who resided with him. An Article Ten Neglect petition was filed on 1/30/17 in the QCFC naming the parents as the respondents. The five CHN were released to the care of the parents with court ordered supervision and mandated services for the parents. Later, the SM gave birth to the SC. An Article Ten Neglect petition was filed on 12/12/17 for the SC. On 10/13/17, the parents accepted an Adjournment in Contemplation of Dismissal (ACD) and nine months suspended judgment. The terms and conditions of the suspended judgment were: parents must cooperate with PPRS, cooperate with drug treatment program, submit to random drug tests and test negative, submit to a clinical health evaluation and cooperate with any recommendations, ensure the CHN are attending school, cooperate with ACS supervision, sign all HIPPAs, ensure the CHN attend all medical appointments and keep home in a safe and sanitary condition.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/12/2017	There was not a fact finding	There was not a disposition
Respondent:	045987 Father Male 33 Year(s)	

Comments:	The SC had five siblings who resided with him. An Article Ten Neglect petition was filed on 1/30/17 in the QCFC naming the parents as the respondents. The five CHN were released to the care of the parents with court ordered supervision and mandated services for the parents. Later, the SM gave birth to the SC. An Article Ten Petition was filed on 12/12/17 for the SC.

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