Child Fatality Report

Report Identification Number: NY-18-121

Prepared by: New York City Regional Office

Issue Date: May 20, 2019

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: 3 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 11/18/2018
Initial Date OCFS Notified: 11/18/2018

Presenting Information

The 11/18/18 SCR report alleged on 11/18/18, the SC was found not breathing on the floor in the home by the SF. The SC had a substance coming out of his mouth. The SF attempted CPR, and then called 911 at approximately 3:44 AM. The SC was then transported to the hospital, and was pronounced dead at the hospital at 4:34 AM. The SC had no visible injuries, and no known pre-existing medical condition. The home environment appeared appropriate. The last time the SC was known to be alive was unknown. The SC was lying in the bed with the SM at an unknown time, before he was found not breathing on the floor. It was unknown how the SC ended up being found on the floor by the SF.

Executive Summary

The 3-month-old male child (SC) died on 11/18/18. The autopsy listed the cause of death as undetermined (Sudden Infant Death; found on the floor after bed sharing with an adult). The manner of death was listed as undetermined.

The allegations of the 11/18/18 report were DOA/Fatality and IG of the SC by the SM and SF.

According to the SF, at about 3:30 AM on 11/18/18, he observed the SC face down on the floor near the SM's bed. The SM and 3-yo SS were asleep on the SM's bed. The SF picked up the SC from the floor and observed that the area from the SC's forehead to his top lip was blue, and a whitish substance came from his nose. He alerted the other household members and the 10-yo SS entered the room and saw him on the floor holding the SC. The SM awoke and the SF told her that he observed the SC on the floor. The 911 operator was contacted, and EMS responded and transported the SC to the hospital. The SF denied he or the SM had a conversation about safe sleep practices with shelter staff or the hospital where the SC was born. He also denied that ACS discussed safe sleep practices with him or the SM.

The SM admitted she slept in the same bed with the SC and 3-yo SS. She said during the night of 11/17/18 she fell asleep with the SC and 3-yo SS in her bed. The SM said during the early morning of 11/18/18, she was awakened by the SF who said the SC was on the floor. The SM said she received safe sleep practice education through the shelter staff as well as ACS.

The 10-yo SS said he overheard the SM state the SC was not breathing. Later, he and the 3-yo SS were interviewed at the CAC. He said the SC was on the bed and the SF was crying. The ACS case record showed the 3-yo SS was asleep at the time the SC was observed unresponsive. The 3-yo SS said they took the SC to the physician. She denied anyone told her the information. She said the SF was crying.

On 11/20/18, ACS filed an Article Ten Neglect petition in Kings County Family Court (KCFC) naming the SF and SM as respondents. KCFC issued a remand of the SS. The allegations included IG of the SS by the SM and SF. The SS were temporarily placed in the care of the PA. ACS consented to a return of the SS based on the preliminary findings of the ME. On 12/7/18, the SM and SF admitted to child neglect. The SS were returned to the SM and SF's care with court ordered supervision. On 12/10/18, ACS opened a preventive services case for the family.

On 1/2/19, LE said the preliminary findings showed there were no suspicions regarding the SC's death. On 1/4/19, the ME said there were no signs of injuries or trauma to the SC's body that explained his death. The SC sustained a skull fracture, but it was considered postmortem. The ME believed this could have occurred when the SC fell from the bed and/or during

the autopsy process.

On 2/21/19, ACS added the allegation of IG of the 10-yo male SS and 3-yo female SS by the SM to the 11/18/18 report. ACS Sub the allegations of DOA/Fatality of the SC and IG of the SC and SS. ACS explained that there was credible evidence to show the SC's death was a direct result of the SM's refusal to practice safe sleep despite being advised to do so on numerous occasions. The SF was aware the SM slept in the bed with the SC despite being counseled on the importance of practicing safe sleep. The SS's emotional state was impacted by the SC's death which was a direct result of the SM's refusal to practice safe sleep.

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:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The 2/21/19 safety assessment document was inadequate as it included associated comments that did not support the selected safety factors or safety decision.
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:	Timely/Adequate 24 Hour Assessment
Summary:	The 11/18/19 safety assessment document was inadequate as it included associated comments that did not support the selected safety factors.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a 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 11/23/18 safety assessment document was inadequate as it included associated comments that did not support the selected safety factors.
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:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	ACS inappropriately substantiated the allegation of IG of the SS by the SM. ACS based the determination on the SS's emotional state and did not justify the BM actions/inaction placed the SS in imminent danger.
Legal Reference:	SSL 412(1) and 412(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:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP did no reflect the case circumstances it did not include the family's history of inadequate/unstable housing condition.
Legal Reference:	18 NYCRR 432.2(d)
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.

Child Fatality Report

Summary:	ACS did not complete the 30-Day Child Fatality Summary Report within the required timeframe. The SCR report was dated 11/18/18 and ACS completed the 30-Day Child Fatality Summary Report on 1/14/19.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/18/2018 **Time of Death:** 04:34 AM

Time of fatal incident, if different than time of death: 03:30 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 03:45 AM
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
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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	Alleged Perpetrator	Male	30 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	10 Year(s)

LDSS Response

On 11/18/18, ACS interviewed shelter staff who said on 10/25/18 the family began to reside in the shelter. The staff said co-sleeping was an ongoing issue. The shelter staff observed the SM was asleep alongside the SC in the bed on 11/14/18. Safe sleep was discussed with the SM. Regarding the incident involving the SC's death, the shelter staff said the family did not notify the shelter of the need for emergency assistance. When EMS staff arrived at the shelter, the shelter staff became aware that the SC was unresponsive.

On 11/18/18, LE informed ACS when they arrived at the home, they observed the SC was on the floor. He was blue, not breathing, and had no pulse. The documentation reflected the case address was a crime scene. The family arranged for the two SS to stay with a relative. The PA agreed to be a resource for the SS.

On 11/18/18, ACS visited the PA’s home to assess the safety of the SS. ACS interviewed the 10-yo SS and the SM. The SM reported she last observed the SC alive on 11/17/18 at 11:00 PM when she placed the SC to sleep in bed with her. The SM said she was awakened by the SF who administered CPR to the SC. The documentation regarding ACS home visit did not state whether there were any safety factors that placed the SS in immediate danger. Later, the SM denied she used drugs or alcohol.

On 11/19/18, school staff said the 10-yo SS did not have behavioral issues. The staff explained there were concerns about this SS's well-being as the SS regularly seemed disheveled.

On 11/19/18, ACS interviewed the two SS and PA about the incident involving the SC's death. The 10-yo SS said he overheard the SM state the SC was not breathing and she called 911. Per this SS's account, the SM slept alongside the SC and 3-yo SS in the bed. ACS attempted to interview the 3-yo SS, but this SS did not respond. The PA said a paternal relative informed her of the SC's death. The PA informed ACS that she had concerns regarding the safety of the CHN while in the SM and SF's care. She explained that during holidays she observed the CHN and they appeared dirty and unkempt.

On 11/23/18, ACS interviewed the SF who said the SM slept alongside the SC in the bed. The SC's crib was in the bedroom where the SF and 10-yo SS slept. The SF said the 3-yo SS did not like to sleep on her bed by herself so she usually slept in the SM's bed alongside the SM and SC. The SF said on 11/18/18, he observed the SC was face down on the floor near the SM’s bed. The SF said he used marijuana, but did not use it in the presence of the CHN.

On 12/10/18, the SM said she attended therapy regularly. The SM said the SF planned to start his therapy at the same location, but his work schedule was an issue.

On 1/9/19, the family was referred to PPRS, and on 3/7/19, the case was reassigned to New York Foundling.

The documentation reflected the SM received counseling at Brooklyn Community Housing and Services, on site preventive services provided by Safe Care, and monitoring and referrals through an on-site social worker. The SM obtained entitlement for permanent housing. The SF did not engage in services due to his work schedule. The Department of Homeless Service discussed with the SM the need to involve the SF in counseling with the SM's service provider.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical 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
049830 - Deceased Child, Male, 3 Mons	049832 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
049830 - Deceased Child, Male, 3 Mons	049831 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
049830 - Deceased Child, Male, 3 Mons	049831 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
049830 - Deceased Child, Male, 3 Mons	049832 - Father, Male, 30 Year(s)	DOA / Fatality	Substantiated
049833 - Sibling, Male, 10 Year(s)	049831 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
049834 - Sibling, Female, 3 Year(s)	049831 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
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?	☒	☐	☐	☐

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

Explain as necessary:
On 11/20/18, ACS filed an Article Ten Neglect petition in KCFC on behalf of the SS. The SS were remanded to the Commissioner of ACS.

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
11/20/2018	There was not a fact finding	There was not a disposition
Respondent:	049831 Mother Female 30 Year(s)	
Comments:	On 11/20/18, ACS filed an Article Ten Neglect petition in KCFC. The SS were remanded to the Commissioner of ACS. The SM and SF consented to the removal of the SS on 11/23/18, but requested a 1028 hearing on 12/3/18 for a return of the SS to their physical care. ACS consented to a return of the SS on 12/7/18 based on the preliminary findings of the ME. On 12/7/18, the SM and SF accepted a 1051a and admitted to neglect. The SS were released to the care and supervision of the SM and SF with the following conditions: they refrain from co-sleeping with the SS, comply with all referrals for intensive PPRS which would include parenting skills, trauma focused therapy/bereavement counseling, trauma focused therapy for the 10-yo SS, drug screen for the SM and SF, and if necessary, compliance with a Certified Alcohol and Substance Abuse Counselor (CASAC) evaluation and follow through with recommendations, and providing the SS's medical, dental, and educational needs.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
11/20/2018	There was not a fact finding	There was not a disposition
Respondent:	049832 Father Male 30 Year(s)	
Comments:	On 11/20/18, ACS filed an Article Ten Neglect petition in KCFC. The SS were remanded to the Commissioner of ACS. The SM and SF consented to the removal of the SS on 11/23/18, but requested a 1028 hearing on 12/3/18 for a return of the SS to their physical care. ACS consented to a return of the SS on 12/7/18 based on the preliminary findings of the ME. On 12/7/18, the SM and SF accepted a 1051a and admitted to neglect. The SS were released to the care and supervision of the SM and SF with the following conditions: they refrain from co-sleeping with the SS, comply with all referrals for intensive PPRS which would include parenting skills, trauma focused therapy/bereavement counseling, trauma	

	focused therapy for the 10-yo SS, drug screen for the SM and SF, and if necessary, compliance with a CASAC evaluation and follow through with recommendations, and providing the SS's medical, dental, and educational needs.

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: PPRS

Additional information, if necessary:
The family received PPRS. ACS offered burial assistance, although the family did not need the financial assistance.

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:
On 11/20/18, ACS filed an Article Ten Neglect petition in KCFC. The two SS were remanded to the Commissioner of ACS. The SS were placed in the care of a resource relative. Subsequently, the SS were released to the care of the SM and SF with ACS supervision.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
On 11/20/18, ACS filed an Article Ten Neglect petition in KCFC. The two SS were remanded to the Commissioner of ACS. The SS were placed in the care of a resource relative. Subsequently, the SS were released to the care of the SM and SF with ACS supervision.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/18/2018	Sibling, Male, 10 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 3 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 1 Months	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 10 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	

Deceased Child, Male, 1 Months	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 10 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 3 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 1 Months	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 10 Years	Father, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 3 Years	Father, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 1 Months	Father, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated

Report Summary:
The 9/18/18 SCR report alleged the SM and SF did not provide adequate housing for the SC and SS. The SM and SF smoked in the home, there was garbage, food and dirty clothes on the floor, and a foul odor. There was limited food for the CHN. At times, the CHN slept on broken mattresses. The SC's crib was cluttered with objects and as a result was co-sleeping with the parents. The 10-yo SS went out of the building unsupervised. It was unknown whether the CHN sustained injuries.

Report Determination: Unfounded | **Date of Determination:** 11/16/2018

Basis for Determination:
ACS based the determination on a lack of credible evidence. Upon arrival to the home, ACS observed there was food in the home for the CHN. The home was observed to be appropriate. The SM tested negative for marijuana or any other substance.

OCFS Review Results:
On 9/18/18, ACS visited the home and observed the SM, SC and SS. The SM said the SF was at work. ACS observed a crib and advised the SM about safe sleep practices for infants. ACS noted there were adequate sleeping arrangements for the SC and SS, and adequate food and clothing. Later, the 10-yo SS informed ACS that the SM always made breakfast and they ate dinner at 7:00 PM. ACS verified the family resided in a shelter for more than a year, and during the period of residence the SM misused drugs. The SC slept with SM in the bed. The shelter staff monitored the sleeping arrangements and observed the SC in the crib on 9/24/18.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
During the interview with the shelter staff on 9/25/18, ACS learned that the SM was observed entering the adult shelter next door to purchase marijuana; however, the documentation of the interview did not reflect that ACS obtained information about the timeline, location/supervision of the SC and SS, and other relevant information about the alleged marijuana purchases.

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.

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

The SF was known to the SCR and ACS in one report dated 4/27/15. The allegation of the report was IG of the 10-yo SS by the SF. On 6/19/15, ACS Unsub the allegation and closed the case with no services required.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

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