Child Fatality Report

Report Identification Number: NY-19-083

Prepared by: New York City Regional Office

Issue Date: Jan 08, 2020 **(Report was reissued on: Jan 21, 2020)**

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: 1 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 07/09/2019
Initial Date OCFS Notified: 07/09/2019

Presenting Information

The narrative of the first report alleged that at an unknown time on 7/9/19, the BM placed the SC in a stroller, lightly covered with a blanket. Shortly afterwards, it was discovered the SC was unresponsive and did not have a pulse. The BM contacted 911, EMS arrived and transported the SC to the hospital. The SC arrived at the hospital at 4:35 PM and at 4:54 PM on 7/9/19, hospital staff pronounced the SC deceased. The SC was born prematurely at 34 weeks with respiratory distress. At the time of her birth, the SC was medically cleared and sent home, with no additional health concerns. At the time of her passing, there was no reason to believe that respiratory distress contributed to the SC's death.

A duplicate report alleged the one-month old child was found dead while in the sole care of the mother. At approximately 4:25 PM the child was cold to the touch, blue and had no pulse while at home. The child was transported to the hospital but was unable to be revived. The report further alleged that prior to her death the child was otherwise healthy.

Executive Summary

On 7/9/19, the SCR registered an initial and subsequent reports alleging DOA/Fatality and IG of the SC by the BM. The autopsy report listed the cause of death as blunt impact of head with skull fracture and the manner of death as homicide (was assaulted).

The narrative of the reports alleged that at an unknown time on 7/9/19, the BM placed the SC in a stroller lightly covered with a blanket. Shortly afterwards, it was discovered the SC was unresponsive and did not have a pulse. The BM contacted 911, and EMS transported the SC to the hospital. The SC arrived at the hospital at 4:35PM, and at 4:54PM on 7/9/19, hospital staff pronounced the SC dead. The SC was born prematurely at 34 weeks with respiratory distress. At the time of her birth, the SC was medically cleared and sent home, with no additional health concerns. At the time of her passing, there was no reason to believe that respiratory distress contributed to the SC's death.

According to the mother, she last saw the child alive at 3:00 PM on 7/9/19 when she gave the child a toy, and at about 4:00 PM, a MA came, touched the child and remarked that the child was cold. The mother said they called 911 for assistance and when the child reached the hospital the child was pronounced dead. The mother also informed the Specialist that her children had recently been trial discharged to her. ACS noted that the mother was nodding off during the interview. Following that interview, neither of the parents made themselves available for any interviews with ACS. The parents secured legal representation and on the advice of their attorney, they refused all interviews. ACS continued to reach out to the attorney; however, there were no changes. No criminal charges have been filed regarding the death of the child.

ACS made assessments of the safety of all the children in the household and appropriately documented their findings in the progress notes and on the safety assessment forms.

ACS maintained contact with many collaterals such as the police ME, schools, case planners from the foster care agency, and other service providers during the course of the investigation. The information obtained was used to assist in case decisions.

On 12/17/19 NYCRO received a copy of the autopsy report which listed the cause of death as blunt impact of head with skull fracture and the manner of death as homicide (was assaulted).

As of the writing of this report, ACS had not yet made a determination on the allegations of case.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
ACS has not yet made a determination on the report; however, casework activity was commensurate with case circumstances.

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:
ACS has not made a determination on the fatality report and there is an open foster care case.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/09/2019 **Time of Death:** 04:53 PM

Time of fatal incident, if different than time of death: 04:55 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 04:26 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
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: Unknown if they were 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	Female	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Other Household 1	Adult Sibling	No Role	Male	18 Year(s)
Other Household 2	Sibling	No Role	Male	15 Year(s)

LDSS Response

On 7/9/19, ACS initiated the investigation by contacting the ER staff. The ER staff reported the SC was brought to the hospital by EMS at 4:43 PM and pronounced dead at 4:53 PM. The cause of death was unknown. The SC did not have any signs of trauma or bruising about the body.

ACS visited the shelter where the family resided. The parents were not present, but the 17-year-old SS was in the home. ACS assessed him to be free of marks and bruises. The SS had limited information about the deceased SC and reported he resided with his birth-father in the Bronx. Also, he was unable to provide any information about the incident. The BPs only informed him that they were at the local NYPD precinct with the MGM. The staff at the shelter did not report any concerns for the family.

ACS then contacted the FCA. The FCA reported that the 6 and 7-year-old SS had been in summer camp with the Fresh Air Fund since 6/30/19, and they were due to return on or about 7/14/19.

On 7/11/19, 7/18/19 and 8/12/19 ACS completed Safety Assessment forms. The safety decision documented on each form accurately reflected case circumstances.

On the same date 7/11/19, An Order to Show Cause was filed for the 9 yo and 8 yo surviving siblings; the parents' visitation was suspended.

On 07/12/19 the Bronx CPS Team interviewed the PA who reported that on 7/9/19 the baby was in the home with her and the parents. The parents left the home at 10:00 AM to pick up their daily methadone dosage; leaving the infant alone with her. According to the PA, she left the child in a stroller that transformed into a bassinet the entire time the parents were out of the home. The PA reported that the infant remained asleep until the parents returned around 12:00 noon. The PA said when the infant became fussy, and the father pushed the infant in the hallway in the stroller to calm her down. The PA said later a neighbor knocked on her door to inquire why the infant was crying and in the hallway, alone. According to the PA, the father had left the infant in the stroller in front of the door while he was smoking and having a conversation with an unidentified individual in the stairway.

The PA said she then went to the hallway and bought the infant back in the apartment; leaving the infant in the stroller in the living room. The PA said she "had a feeling" to go to the stroller to check the infant and upon doing so she noticed that the baby had a faint heartbeat. She then ran into the bedroom where the parents were and told them something was wrong with the baby. A brother also came to the home and he called 911.

According the to the Bronx North CPS team, the PA appeared to be very cautious and guarded with information throughout the interview, and there were gaps in her account. For example in the timeline of events provided by the PA the incident occurred between noon and 1:00 PM; however, 911 was called at 4:24 PM. NYPD officers arrived at the house at 4:26 PM and did not wait for EMS. Instead, they ran downstairs with the infant to EMS. EMS arrived at the hospital at 4:33pm. At 4:53 PM the baby was pronounced dead.

On 7/13/19 the surviving minor children were returned to kinship care with the MGM.

On 07/15/19, an Article 10 Petition of Abuse was filed in the Kings County Family Court against the parents of the deceased child and the PA on behalf of PA's child, and the surviving siblings including the 17 -year-old child, and the father's 15 -year-old child from another relationship. The Court granted the continued remand for 9-year-old and 8-year-old children. The Court remanded the PA's child and the child was removed and placed with her former foster parent under the auspices of Catholic Guardian Society. The Court released 17-year-old to his non-respondent father when, during the investigation, the child reached the age of 18. The 15-year-old sibling from the father's other relationship was also assessed and released to his mother. There were no concerns regarding his care.

Between 7/15/19 and 8/12/19, ACS interviewed the mother who reported she had last seen the child alive at 3:00 PM on 7/9/19 when she gave the child a toy, and at about 4:00 PM a MA came, touched the child and remarked that the child was cold. The mother said they called 911 for assistance. ACS noted that the mother was nodding off during the interview. The mother also informed the Specialist that her children had recently been trial discharged to her. Following that interview, neither of the parents made themselves available for any interviews with ACS. The parents secured legal representation and on the advice of their attorney, they refused all interviews. ACS continued to reach out to the attorney; however, the attorney still continued to deny ACS' request for contact with the parents.

ACS maintained contact with many collateral such as the police ME, schools, case planners from the foster care agency, and other service providers during the course of the investigation. The information obtained was used to assist in case decisions.

On 12/17/19, NYCRO received a copy of the autopsy report which listed the cause of death as blunt impact of head with skull fracture and the manner of death as homicide (was assaulted).

As of the writing of this report, ACS had not yet made a determination on the allegations of case..

Official Manner and Cause of Death

Official Manner: Homicide
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)?Yes
Comments: Case documentation reflected a MDT response to this fatality.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team (CFRT) in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052582 - Deceased Child, Female, 1 Mons	052583 - Mother, Female, 36 Year(s)	DOA / Fatality	Pending
052582 - Deceased Child, Female, 1 Mons	052583 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Pending
052582 - Deceased Child, Female, 1 Mons	052583 - Mother, Female, 36 Year(s)	Internal Injuries	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐

Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
After the initial interview with the mother, the parents refused all contact with ACS on the advice of their attorney.

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?	☒	☐	☐	☐
Explain: Assessment of safety was completed.				

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?	☐	☒	☐	☐
Explain as necessary: Children were already in care but were on trial discharge to the parents. They were physically away at a camp when the fatality occurred. The siblings were physically removed from the home				

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:**
07/15/2019	There was not a fact finding	Article 10 Remand
Respondent:	052583 Mother Female 36 Year(s)	
Comments:	Continued remand of the surviving minor children of the mother and father of the now deceased child.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/15/2019	There was not a fact finding	Article 10 Remand
Respondent:	051301 Other	
Comments:	The PA's child was removed and placed in non-kinship foster care.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/15/2019	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	052584 Father Male 38 Year(s)	
Comments:	A continued remand of the father's children with the mother of the now deceased child was granted by the court. The father's 15-year-old child from a previous relationship was released to his mother.	

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:
ACS was unable to offer any services to the parents as they refused all contact with the agency on the advise of their attorney.

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:
Siblings were provided with bereavement counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Parents did not maintain any contact with ACS on the advice of their attorney.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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? Yes
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)
05/30/2019	Sibling, Female, 8 Years	Mother, Female, 35 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Female, 8 Years	Mother, Female, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 7 Years	Mother, Female, 35 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 7 Years	Mother, Female, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Male, 1 Days	Mother, Female, 35 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 1 Days	Mother, Female, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 8 Years	Father, Male, 38 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 8 Years	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 7 Years	Father, Male, 38 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 7 Years	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Male, 1 Days	Father, Male, 38 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 1 Days	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
On 05/30/19, the SCR registered a report with the allegation Inadequate Guardianship of the newborn female child (SC in the fatality report). It was alleged the mother gave birth to a baby girl on 5/29/19 and there were concerns for the parent's ability to properly care for the infant. The mother and father had their two other children removed from their care due to neglect, and the children have yet to be returned into the mother and father's custody.

Report Determination: Indicated | **Date of Determination:** 12/27/2019

Basis for Determination:
On 12/27/19 ACS indicated the report for allegations of Parents Drug/Alcohol Misuse and Inadequate Guardianship of the newborn, and the 9-year-old and 8-year-old children by the parents based on the parents long history of substance abuse, misuse of methadone, and the statements by the children who described the parents as being "high" and were "acting weird". Additionally, ACS documented the MGM observed the parents to be "nodding and falling asleep while in the home." further ACS staff documented the home conditions were deplorable despite the fact that the parents had " more suitable living accommodations in a family shelter scatter site."

OCFS Review Results:
ACS initiated the investigation in a timely manner by conducting an assessment of the newborn in the hospital, interviewing the parents, hospital staff, the mother's substance abuse counselor. ACS learned the newborn had a low birth weight; however, the child was cleared for discharge as the child was feeding on her own. A child Safety conference was convened on 6/4/19 and the outcome was for the filing of an Article 10 petition seeking a remand. Kinship resources were identified.

On 06/06/19 ACS staff successfully interviewed the mother who reported that during her pregnancy she continued to attend her methadone program; she had been attending since 2017. The mother said her methadone dosage was being reduced and that the infant was doing well in the hospital. The mother reported she had a stroller, car seat, and "plenty of clothes" for the infant.

On 06/06/19, the CPS team also interviewed father who reported his wife was about two months pregnant when they learned she was pregnant. The father said the family was doing well. However, when the CPS team contacted the substance abuse case manager, ACS learned been receiving the same dosage from the time she has started the program and the program had not known of the mother's pregnancy.

On 06/26/19, the then 8-year-old and 7-year-old children were trial discharged to parents.

On 7/9/19 while investigating the allegation of the 5/30/19 report, ACS learned of the death of the newborn. ACS combined the investigations of both reports.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/10/2018	Sibling, Female, 6 Years	Mother, Female, 34 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 7 Years	Mother, Female, 34 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6 Years	Father, Male, 37 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 7 Years	Father, Male, 37 Years	Inadequate Guardianship	Substantiated	

Report Summary:
It was alleged that on 4/9/18 at 11:53 PM the parents went over to the grandmother's residence to obtain their children; the MGM had physical custody of the children. The parents became physical with the MGM in the presence of both children. The children were placed at risk but not harmed. Both parents were arrested as a result of the incident. The allegations of the report were sexual Abuse and inadequate Guardianship of the children by the parents.

On 4/23/18 another report was registered with allegation of Sexual Abuse of the children by the MU. According to the report, the adult uncle was sexually abusing the six-year-old and seven-year-old children by touching their private areas making them uncomfortable. The report stated the other family members have unknown roles. This intake was closed as a duplicate on 4/26/18.

Report Determination: Indicated	**Date of Determination:** 06/05/2018

Basis for Determination:
ACS indicated the report on the basis of credible evidence to substantiate the allegations. It was established that the parents went to the MGM's home and had a physical altercation with the MGM in the presence of the children. The parents attempted to forcibly remove the children from the home. Law enforcement intervened and the parents were arrested.

ACS unsubstantiated the allegation of Sexual Abuse of the children by the MU on the basis of the children's denial that they were touched.

OCFS Review Results:
ACS did not conduct a thorough investigation of this report or a subsequent report dated 4/23/18, which was closed inappropriately closed as a duplicate on 4/26/18. The subsequent report listed a MU as the subject for allegation of sexual abuse of the two girls and resided in a separate household. Although the reports listed the parents and the MU as the subjects of the report, the case name was listed as the MGM even though she was only the temporary guardian of the children. The children were placed in her care through other arrangements made with the family.

ACS did not make relevant and/or enough collateral contacts to properly address this investigation. There was no contact with the staff at the children' schools, pediatricians, family members, NYPD or FCLS.

The mother alleged that although there was a limited OOP, she usually took the children to school as oppose to the MGM. This matter was not explored with the school staff; which was needed to assess the safety of the children and explore the mother's demeanor, the MGM's involvement with the school staff to address the children' adjustment after the removal, and to confirm that medical documentation for one of the children was on file as well as a copy of the OOP. In addition, even though the MGM nor her child, 15 y.o. MU, were not listed with a role in the report, contact should have been made with his school as well.

There was no contact with the children's pediatrician to follow up on their medical needs. Specifically, to confirm that the child with the medical condition had a prescription for her prescribe medication and that the paperwork needed for the school had been issued. Also, to explore and obtain relevant information about the parent's ability to care for the children and any concerns about their demeanor or interaction with the children.

Both parents expressed they preferred the children to be in the custody of other family members; however, ACS made no efforts to obtain names and/or contact information. This was relevant to explore the parents' drug use and the mother's mental health. These were issues that were prominent in the history as well as in the current report. Also, the NYPD stated the mother was taken to the psychiatric unit at the hospital on the day of the incident and both parents appeared to be under the influence of drugs. ACS failed to explore and add the allegation of PD/AM to the report. ACS documented that the mother agreed to submit to a random drug screening, but there was no follow up.

The documentation did not reflect there was a discussion with FCLS to alert them of the reported incident. Also, to have mandated services for the parents to address the mental health and substance abuse issues that arose during this investigation as well as in the family's history. It was evident that the prescribed or not prescribed medication the parents consumed impacted on the ability to care for the children, behavior as well as their judgement.

ACS failed to address numerous discrepancies that arose in the family's accounts relevant to the incidents, which

impacted on the ability to properly assess the safety of the children in the care of the parents and also the MGPs. In addition, the completion of the safety instrument was not done appropriately as the safety factors were not supported by the comments.

The allegation referring to the SA by the MU was not properly explored, the allegation was unfounded based on the children's denial of being touched by anyone inappropriately, but there was no CAC involvement.

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

Issue:
Failure to provide notice of report
Summary:
ACS did not issue the Notice of Existence to all of the subjects of the report
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to Provide Notice of Indication
Summary:
ACS did not provide the Notice of Indication to all the subjects of the report.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
ACS did not conduct a thorough investigation of this report or a subsequent report dated 4/23/18, which was closed inappropriately closed as a duplicate on 4/26/18. The subsequent report listed a MU as the subject for allegation of sexual abuse of the two girls and resided in a separate household. Additionally, ACS did not address numerous discrepancies that arose in the family's accounts relevant to the incidents, which impacted on the ability to properly assess the safety of the children in the care of the parents and also the MGPs. Furthermore, ACS did not conduct a thorough review of the history of this family as it pertained to mental health and drug use. In addition, relevant information regarding the parents use of drugs was not explored further with collaterals. For example, the NYPD stated the mother was taken to the psychiatric unit at the hospital on the day of the incident and both parents appeared to be under the influence of drugs. ACS failed to explore and add the allegation of PD/AM to the report. ACS documented that the mother agreed to submit to a random drug screening, but there was no follow up. ACS also did not update the CONNECTIONS database to accurately reflect case circumstances for the report. Although the reports listed the parents and the MU as the subjects of the 4/23/18 report, the case name was listed as the MGM's. Lastly, the allegation referring to the SA by the MU was not properly explored, the allegation was unfounded based on the children's denial of being touched by anyone inappropriately, but there was no CAC involvement.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
The completion of the safety instrument was not done appropriately as the safety factors were not supported by the comments.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS did not make relevant and/or enough collateral contacts to properly address this investigation. There was no contact with the staff at the children' schools, pediatricians, family members, NYPD or FCLS.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
ACS's documentation of Progress Notes was not clear and concise. Many question on the progress note templates were not completely answered.
Legal Reference:
18 NYCRR 428.5
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/17/2018	Sibling, Male, 16 Years	Mother, Female, 34 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 16 Years	Mother, Female, 34 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 16 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 6 Years	Mother, Female, 34 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6 Years	Mother, Female, 34 Years	Lack of Supervision	Substantiated	

Sibling, Female, 6 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 5 Years	Mother, Female, 34 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 5 Years	Mother, Female, 34 Years	Lack of Supervision	Substantiated
Sibling, Female, 5 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Male, 16 Years	Father, Male, 37 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 16 Years	Father, Male, 37 Years	Lack of Supervision	Substantiated
Sibling, Male, 16 Years	Father, Male, 37 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 6 Years	Father, Male, 37 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 6 Years	Father, Male, 37 Years	Lack of Supervision	Substantiated
Sibling, Female, 6 Years	Father, Male, 37 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 5 Years	Father, Male, 37 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 5 Years	Father, Male, 37 Years	Lack of Supervision	Substantiated
Sibling, Female, 5 Years	Father, Male, 37 Years	Parents Drug / Alcohol Misuse	Substantiated

Report Summary:
On 02/17/18 it was reported that parents abuse methadone and marijuana to impairment and would often leave the drugs and drug paraphernalia accessible to the children in the home. It was alleged this was an ongoing situation. It was further alleged that on 2/17/18, at about 8:50 AM, the parents left the children unattended for at least 2 hours. It was also reported that on 2/17/18, the parents left the 6 y.o and the 7 y.o children alone in the home for at least an hour. The report stated the children did not know the parents' whereabouts. The report stated that upon return to the home the parents were arrested.

Report Determination: Indicated | **Date of Determination:** 04/18/2018

Basis for Determination:
ACS substantiated the allegations of PD/AM, LS, and IG of the 6 and 7 yo children against the parents. ACS based their decision on the fact that the parents left the children unattended for several hours unsupervised to purchase drugs. There was no narrative provided for the allegation of IG of the 6 yo and the 7 yo children by the parents.
The allegations of IG and PD/AM of the 16 yo were unsubstantiated against the parents as he was not in their care.

OCFS Review Results:
In practice, ACS took appropriate action to ensure the physical safety of the children. Based on the parents' actions and their CPS history. ACS took appropriate action and filed an Article 10 Petition of Neglect in Family Court and obtained a remand of the 6 yo and the 7 yo children. The two were placed in the care of their MGM. The 15yo remained with his father; however, he evaded ACS and no one was able to obtain his father's address. ACS' investigation reflected poor documentation and completion of the safety assessments and determination narratives.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
ACS chose a safety decision noting that the family's whereabouts were unknown which was not consistent with the case circumstances. Also, the safety factors selected were not supported by the comments.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
ACS chose a safety decision noting that the family's whereabouts were unknown which was not consistent with the case circumstances. Also, the safety factors selected were not supported by the comments.

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

Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/15/2017	Sibling, Female, 5 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 5 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 5 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 5 Years	Father, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 7 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Father, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The SCR registered a report that the parents were under the influence of an unknown substance while while caring for he children and picking them up from school. The report stated the father was also observe nodding off as he was helping them to get dressed.

Report Determination: Unfounded | **Date of Determination:** 02/13/2018

Basis for Determination:
ACS unsubstantiated the allegations of PD/AM and IG of the children based on their observation during home visits which did not indicate the parents were under the influence of drugs or alcohol and interviews with the children.

OCFS Review Results:
The report was initiated timely.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/07/2016	Sibling, Male, 14 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Sibling, Male, 14 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 14 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 6 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 6 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 5 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 5 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 14 Years	Father, Male, 35 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Male, 14 Years	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 14 Years	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 6 Years	Father, Male, 35 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 6 Years	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 6 Years	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 5 Years	Father, Male, 35 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 5 Years	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 5 Years	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The SCR registered a report alleging that the father would physically assault the mother in the presence of the children. The report stated the police had often called out to the home due to the DV. The report stated the parents used multiple types of pills to the point they were unable to adequately care for the children. The report also alleged the home was filthy and cluttered with debris, junk, laundry, and bags of garbage. It was also reported there were dirty dishes throughout the home, and rotten food on the floors; which cause the home to be infested with cockroaches. The family was residing in a shelter since 2014.

Report Determination: Indicated	**Date of Determination:** 09/16/2016

Basis for Determination:
ACS substantiated the allegations of PD/AM of the children by the mother and unsubstantiated the allegation against the father. However, there was no narrative to support the allegation against the mother. ACS substantiated the allegation of IG of the children by the parents. Based on a prior indicated report involving DV and the fact that they did not follow through with ACS' referral. ACS unsubstantiated the allegations of I/F/C/S of the children by the parents citing they had "insufficient evidence" and the home was appropriate for the children. ACS cited there was no credible evidence.

OCFS Review Results:
ACS' investigation was not thorough as the documentation of progress notes, assessments, and determination narratives were not clear and concise. Also, several progress notes were not entered timely. In addition, relevant directives in this case were not made timely as court intervention was delayed, and this interfered with the assessment of the children and the home. Collateral contacts were not made with the NYPD, hospital staff pertaining to the 14 yo's incident that led him to be hospitalized, or the school staff to assess the parent's ability to care for the children and their overall demeanor. There were no supervisory strategies evident, based on the case circumstance in a timely manner.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The safety decision selected was not supported by the selected safety factors as the comments had no substance. Also, all areas of the template were not completed properly.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate 30-Day Safety Assessment
Summary:
The safety decision selected was not supported by the selected safety factors as the comments did not adequately reflect case circumstances. Also, all areas of the template were not completed properly.
Legal Reference:
CPS Program Manual, Chapter 6, K-2
Action:
ACS must meet with the staff involved in thisinvestigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to provide notice of report
Summary:
ACS did not provide a Notice of Existence (NOE) for the 14 yo's father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:

ACS must meet with the staff involved in thisinvestigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to Provide Notice of Indication
Summary:
ACS did not provide a Notice of Indication to the 14 yo's father.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Pre-Determination/Supervisor Review
Summary:
Throughout the investigation there was inadequate supervisory guidance; this was evident as documentation that was not completed properly was approved without corrections.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Adequacy of Progress Notes
Summary:
The Progress Notes were not clear and concise as they were not detailed and several notes were not entered timely.
Legal Reference:
18 NYCRR 428.5
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/13/2016	Sibling, Male, 14 Years	Other Adult - 14 yo's father, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The SCR registered a report alleging that on 5/12/06 the father pulled a handgun on the mother in of the then 14 yo sibling. The report stated the father was not under the influence of any substance nor had any mental health issues. The report stated the mother was attempting to take the 14 yo to her residence.

Report Determination: Unfounded | **Date of Determination:** 07/12/2016

Basis for Determination:
ACS unsubstantiated the allegation of IG citing they were unable to gather "insufficient" credible evidence to verified the the then 14 yo sibling's father brandished a gun against the mother when she attempted to pick up the SC. ACS based their decision on the mother's inability to provide an exact location which led them to suspect the possibility that she that she might have falsified a report.

OCFS Review Results:
ACS did not conduct a thorough investigation and did not complete the safety assessments properly. Safety assessments were approved even though they were improperly completed. There appeared to be a lack of supervisory guidance as the directives were not consistent with the case circumstances. Also, the required Notices of Existences (NOE) were not issued.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
ACS selected a safety decision noting there were safety factors that did not placed the children in immediate risk of harm but did not list any factors to support the safety decision. The instrument in its entirety was not completed properly.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
.

Issue:
Failure to provide notice of report
Summary:
ACS did not provide a notice of existence to the father of the 14 yo who was the subject of the report, and the mother.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
...

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
ACS selected a safety decision noting there were safety factors that did not placed the children in immediate risk of harm, however, the supportive narratives for the selected safety factors had no substance. The instrument in its entirety was not completed properly.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
...

Issue:
Pre-Determination/Supervisor Review
Summary:
There appeared to be a lack of supervisory guidance as the directives were not consistent with the case circumstances.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
Action:
...

[redacted]

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

Between 2007 and 2015, the family was known to the SCR and ACS in reports registered on 2/10/07, 8/8/11, 10/13/2011, 8/3/12, 4/10/14, and 11/20/15. These reports had repeated combinations of allegations pertaining to Educational Neglect, Drug misuse and Inadequate Guardianship of the children in the home. There were arrests of the adults involved, as DV was a concern. The allegations of reports dated 2/10/07 and 8/8/11 were substantiated against the father of the 14-year-old child while the 11/20/15 report was indicated against the father of the SC in the fatality report for the allegation of IG. The father assaulted the mother (of the SC in the fatality report) in the presence of the then 5-year-old and 4-year-old children. He was arrested and issued an OOP. The mother refused services. The case closed on 2/22/16.

The 10/13/11 and 8/3/12 report were unfounded against the father of the now deceased child and the mother for allegations of Educational Neglect and IG of the children in the home. The family was referred for Community-based services. The report dated 4/10/14 was unfounded against the mother in the fatality report for allegations of Burns, Scalding, and IG of the then 13-year-old subject child. No services were provided.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Services Open at the Time of the Fatality

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: 08/16/2018

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
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?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☐	☒	☐	☐

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?	☐	☐	☒	☐

Foster Care at the Time of the Fatality

The deceased child(ren) were in foster care at the time of the fatality? Yes
Date deceased child(ren) was placed in care: 02/20/2018
Date of placement with most recent caregiver? 02/20/2018
How did the child(ren) enter placement? Court Order

Review of Foster Care When Child was in Foster Care at the time of the Fatality

	Yes	No	N/A	Unable to Determine
Does the case record document that sufficient steps were taken to safeguard this child's safety while in this placement?	☒	☐	☐	☐
Did the placement comply with the appropriateness of placement standards?	☒	☐	☐	☐
Was the most recent placement stable?	☒	☐	☐	☐

Did the agency comply with sibling placement standards?	☒	☐	☐	☐
Was the child AWOL at the time of death?	☐	☒	☐	☐

Visitation

	Yes	No	N/A	Unable to Determine
Was the visitation plan appropriate for the child?	☒	☐	☐	☐
Was visitation facilitated in accordance with the regulations?	☒	☐	☐	☐
Was there supervision of visits as required?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource made with required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource in the parent/relative/discharge resource's home made with required frequency?	☒	☐	☐	☐
Were all of the casework contact requirements for contacts with the caretakers made, including requirements for contact at the child's placement location?	☒	☐	☐	☐

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the agency provide the foster parents with required information regarding the child's health, handicaps, and behavioral issues?	☒	☐	☐	☐
Did the provider comply with discipline standards?	☒	☐	☐	☐
Were the foster parents receiving enhanced levels of foster care payments because of child need?	☐	☐	☒	☐
If yes, was foster parent provided a training program approved by OCFS that prepared the foster parent with appropriate knowledge and skills to meet the needs of the child?	☒	☐	☐	☐
Was the certification/approval for the placement current?	☒	☐	☐	☐
Was a Criminal History check conducted? **Date:** Unknown	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:**	☐	☐	☐	☒

Was a check completed through the Staff Exclusion List? **Date:**	☐	☐	☐	☒
Additional information, if necessary: No additional information.				

Foster Care Placement History

An Article 10 Petition of Neglect was filed on 2/20/18 in the Kings County Family Court against respondent parents in the fatality report on behalf of the then 16-year-old, 8-year-old, and 7-year-old children for concerns of Inadequate Guardianship and Lack of Supervision. The parents left the 8-year-old, and 7-year-old subject children in the shelter unit unsupervised. Law Enforcement was called, and the parents were arrested. A remand of the 8-year-old and 7-year-old children was granted. The children were placed in foster care with the NY Foundling Foster Care agency. On 7/13/19, following the death of the one-month-old infant, the children returned to their kinship placement with the MGM and the court continued the remand.

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:**
02/20/2018	There was not a fact finding	Article 10 Remand
Respondent:	052583 Mother Female 36 Year(s)	
Comments:	The minor surviving siblings were remanded and placed in the care of the MGM under the auspices of NY Foundling Foster care agency. The 18-year-old child was released to his father.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/20/2018	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	052584 Father Male 38 Year(s)	
Comments:	Siblings remanded.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
08/16/2016	There was not a fact finding	Order of Supervision
Respondent:	052583 Mother Female 36 Year(s)	
Comments:	Order of Supervision granted by the Family Court.	

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
08/16/2016	There was not a fact finding	Order of Supervision
Respondent:	052584 Father Male 38 Year(s)	
Comments:	Children released to mother with ACS supervision.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/07/2019	There was not a fact finding	There was not a disposition
Respondent:	052583 Mother Female 36 Year(s)	
Comments:	The petition is pending.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/07/2019	There was not a fact finding	There was not a disposition
Respondent:	052584 Father Male 38 Year(s)	
Comments:	Petition is pending	

Have any Orders of Protection been issued? Yes	
From: 08/16/2016	**To:** Unknown
Explain: On 8/16/16, an Article 10 Petition was filed in Bronx Family Court against parents on behalf of the minor subject children for concerns of Inadequate Guardianship/ Domestic Violence as the father punched the mother in the mouth in the presence of the children. The Court issued an Order of Protection against father on behalf of the mother and minor children.	

Additional Local District Comments

N/A

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