Child Fatality Report

Report Identification Number: NY-16-108

Prepared by: New York City Regional Office

Issue Date: May 30, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	

Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
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	

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 10/27/2016
Initial Date OCFS Notified: 10/27/2016

Presenting Information

The 10/27/16 SCR report alleged on 10/27/16 the SM was co-sleeping with the 3-month-old female infant. The report also alleged the SM rolled over infant. As a result the infant was found unresponsive with dried blood under her nose. The infant was pronounced deceased at 5:00 a.m. on 10/27/16. The aunt, grandmother, and 5-year-old child had unknown roles.

Executive Summary

The 3-month-old female infant died on 10/27/16. ACS made multiple attempts to obtain the ME's report but he efforts were unsuccessful due to pending autopsy. As of 3/28/17, NYCRO has not yet received the autopsy report.

The allegations of the 10/27/16 report were DOA/Fatality, II and IG of the SC by the SM.

ACS interviewed the SM who said on 10/27/16 she left the home at approximately 7:30 p.m., and went to a social event with her friend. The SM disclosed to ACS that during the social event, she used 3 "blunts of marijuana" and drank an alcoholic beverage. ACS documented that the SC and the SS were left in the care of the MGF and MA. SM said she returned home at approximately 11:00 p.m. Upon her return to the home, the SM fed the SC 6 to 8 ounces of formula with cereal, shortly after 11:00 p.m. The SM fell asleep in the queen size bed, prior to changing the SC's diaper, and awoke at about 3:30 to 4:00 a.m. and observed the SC was not moving. The SM contacted 911 for medical assistance, followed the instructions and performed CPR on the SC. EMS responded to the home at approximately 4:20 a.m. and observed the infant on the sofa. The infant was bleeding from the nose. EMS attempted to resuscitate the SC and transported the SC to St. Barnabas Hospital. ACS learned that the half sibling was in the home; in the care of the MA.

ACS staff observed and engaged the half sibling in school on 10/27/16. The half sibling said the SC was unable to move and there was blood in the SC's nose. The half sibling said the SM’s cries woke the children who were in the home. ACS staff conducted a body check and found the half sibling did not have marks/bruises indicative of abuse/maltreatment. ACS conducted an emergency removal of half sibling and placed her with the MA.

ACS held a Child Safety Conference on 10/28/16. ACS filed an Article Ten Neglect petition in Bronx County Family Court on behalf of the half sibling, naming the SM as the respondent. On 10/31/16, the half sibling was remanded to the care and custody of the Commissioner of ACS. The half sibling was returned to the SM's care on 11/04/16. The SM agreed to the following stipulation set forth by Bronx Family Court; SM to follow up with substance abuse program and bereavement counseling, comply with home visits and any other reasonable referrals. ACS documented advising the SM that any contact between half sibling and the BF should be supervised at the agency.

ACS maintained contact with the family and found the SC appeared to be doing well in the SM’s care. ACS staff provided the SM with a referral to the Montefiore New Directions substance abuse program. ACS conducted a joint home visit with the Supportive Children's Advocacy Network New York (SCAN-NY) preventive agency. The SM agreed to engage in substance abuse treatment, counseling and other preventive programs through the SCAN preventive program.

On 1/26/17, ACS substantiated the allegation of IG of the SC by the SM on the basis that the SM admitted she slept alongside the SC in the bed although the SC had a functional crib. The SM said she was advised of the safety and risk factors of co-sleeping with the SC by the hospital staff when she gave birth. The SM said during the social event on 10/27/16, she used marijuana" and drank an alcoholic beverage before getting into bed alongside the SC. The SC was found unresponsive when the SM woke and was declared deceased on 10/27/16 at the hospital.

ACS unsubstantiated the allegation of DOA/fatality and II of the SC by the SM on the basis of finding of no credible evidence to substantiate the allegations. ACS noted that the SC's death appeared to be a rollover and the ME's findings were pending. ACS added that the initial report from the ME 's officer did not inform the agency that the SC died as a result of injuries inflicted on her by a caretaker or respondent SM.

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Failure to Provide Notice of Indication
Summary:	ACS did not provide SM with Notice of Indication.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed. ACS must submit a performance improvement plan

	within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	ACS received the report on 10/27/16 and did not submit the 30-day Fatality Report in a timely manner. The 30-day report was completed on 12/2/16.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed. ACS must a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Child Protective Services casework contacts
Summary:	During the investigation ACS noted the MA, and 5-year-old maternal cousin, were in the home on 10/27/16 at the time of the incident involving the SC's death. ACS did not document in progress notes whether the maternal cousin was assessed.
Legal Reference:	432.2(b)(4)(vi)
Action:	ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed. ACS must submit a performance improvement plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/27/2016 **Time of Death:** 05:00 AM

Time of fatal incident, if different than time of death: 04:00 AM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: 04:17 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

☒ Drug Impaired
☒ Alcohol Impaired
☐ Distracted
☐ Impaired by disability
☐ Absent
☐ Asleep
☐ Impaired by illness
☐ 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	Female	3 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Other Child	No Role	Female	5 Year(s)

LDSS Response

The ACS Emergency Children Services (ECS) staff initiated the investigation by contacting Law Enforcement (LE). ACS learned the SM appeared distraught and in disarray after SC death. ACS documented that the SC was observed by LE, on the sofa, bleeding from her nose. The SM was attempting CPR when LE responded to the case address. ACS staff interviewed LE who said at approximately 4:00 a.m. on 10/27/16, the SM obvserved the infant was not moving. The SM alerted the MA who contacted 911. EMS responded and transported the SC to St. Barnabas Hospital where the SC was pronounced dead at 5:00 AM.

An Investigative progress note dated 10/27/16 noted that ACS staff visited the half sibling's school. An emergency removal of the half sibling was conducted and a safety plan was initiated. ACS attempted telephone contact with the half sibling's BF; however, ACS was unsuccessful and there were no other contacts made. Subsequently, ACS placed the half sibling with the MA. ACS staff interviewed the SM, and documented the SM admitted to using alcohol prior to sleeping alongside the SC in the bed. The SM admitted receiving counseling about safe sleep practices when the SC was born in the hospital. ACS had provided the SM with a crib in a prior ACS investigation.

On 10/28/16 ACS held an Initial Child Safety Conference (ICSC). The outcome of the ICSC was remand of the half sibling to the Commissioner of ACS. ACS staff filed an Article Ten Neglect Petition in the Bronx County Family Court (BxCFC); the petition was drafted and ACS was advised to return to Bronx Family Court on 10/31/16. ACS made phone contact with the Bronx District Attorney's Office on 10/28/16, and learned; the SM was not charged with a crime. ACS returned to the BxCFC on 10/31/16 and filed the Article Ten Neglect petition against BM on behalf of the half sibling. The court granted ACS a remand of the half sibling. ACS placed the half sibling in a foster boarding home under the supervision of the Graham Windham (GW) foster care agency.

On 11/4/16 a BxCFC judge ordered the return of SC to the SM. The ACS Family Court Legal Services attorney basis for the half sibling's release to the SM included ACS not observing marks or bruises on the half sibling's body. The LE, DA and ME's preliminary findings did not reveal a criminal act related to the death of SC. The stipulation of the release included; several service intervention related conditions and a period of 12 months of ACS supervision.

On 11/12/2016, ACS documented a funeral viewing and cremation took place of SC. ACS documented that a 20-day conference was held on 11/21/16; SM did not attend. ACS obtained information from through interviews with multiple relatives and found that there were no concerns with the care SM had provided SC and half sibling.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
034041 - Deceased Child, Female, 3 Mons	034043 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
034041 - Deceased Child, Female, 3 Mons	034043 - Mother, Female, 25 Year(s)	Internal Injuries	Unsubstantiated
034041 - Deceased Child, Female, 3 Mons	034043 - Mother, Female, 25 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?	☒	☐	☐	☐
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 safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

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

investigation?				
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
On 10/31/16 the half sibling was remanded to the care and custody of the Commissioner of ACS. The half sibling was placed with Graham Windham (GW) foster care agency.

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:**
10/31/2017	There was not a fact finding	There was not a disposition
Respondent:	034043 Mother Female 25 Year(s)	
Comments:	On 10/31/16, ACS filed an Article Ten Neglect petition in the BxCFC against BM on behalf of the half sibling. The judge granted ACS remand of the half sibling. Subsequently, the judge released the half sibling to the SM with ACS supervision on 11/4/16. ACS attended court hearing on 2/8/17 for fact finding; however, the hearing was adjourned because the ME's final report was not available. The next BxCFC hearing was scheduled for 4/20/17 (fact finding).	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐

Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☒	☐	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☒	☐	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: As of 3/28/17, the case remains open for Court Ordered Supervision with ACS.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The half sibling was provided with bereavement counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM received funds to assist with the burial of the SC. SM was referred to substance abuse treatment and bereavement counseling.

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)	Status/Outcome	Compliance Issue(s)
07/11/2016	14311 - Deceased Child, Female, 1 Days	14313 - Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	Yes
	14311 - Deceased Child, Female, 1 Days	14313 - Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:
The 7/11/16 SCR report alleged that the SM gave birth to the infant in July 2016 and tested positive for marijuana and was therefore not able to adequately care for the infant. The report stated further details were unknown. The roles of the 4-year-old half sibling and the infant's father were unknown.

Determination: Unfounded
Date of Determination: 09/08/2016

Basis for Determination:
ACS unsubstantiated the allegation of IG of the SC by the SM on the basis of no finding of credible evidence to suggest the SM did not provide the SC with adequate care. ACS added that the SC's basic needs were met and the SC was always supervised by the SM and BF.

ACS unsubstantiated the allegations of PD/AM of the SC by the SM on the basis that there was no credible evidence to suggest the SM's drug use had an impact on the SC. The SC tested negative for marijuana at birth, although the mother tested positive. The SM did not comply with subsequent drug testing. The SC's basic needs were met.

OCFS Review Results:
On 9/8/16, ACS closed the 7/11/16 investigation although the directives provided by the ACS supervisor were not addressed. There were missing collateral contacts with relatives, medical personnel and consultants. There was inadequate/missing assessment of the SC. The ACS staff did not complete the ACS protocols for substance abuse screening. There was no ACS management oversight of the case. In the 7/15/16 and 9/6/16 safety assessments, ACS identified the SM's drug use as a safety factor that placed the children in immediate danger. However, ACS did not complete a safety plan. The 9/6/16 Investigation Determination safety assessment did not include updated information.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
ACS completed the investigation without making successful contact with the hospital staff who had information about the event surrounding the SC's birth. ACS did obtain relevant information from pertinent collateral contact regarding the history of the SM's drug use.

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

Action:
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed. ACS must 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 inappropriately completed the Investigation Determination safety assessment. ACS identified the SM's drug use as a safety factors that placed the SC in immediate or impending danger of serious harm. However, ACS closed the investigation without making diligent effort to address the SM's drug use. ACS noted a safety plan was necessary but did not implement safety intervention.

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

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

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
ACS completed and approved the investigation determination although directives provided by the supervisor were not addressed. There were missing collateral contacts, inadequate interviews, and no ongoing assessment of SC. ACS did not complete the relevant drug screening protocols. ACS was not in compliance with case closing standard.

Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)

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

[redacted]

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

The SM was known to the SCR and ACS in three reports dated 11/8/11, 12/17/11 and 6/23/12.

The SM was listed as a Non-Confirmed Subject in the report dated 11/08/2011 and she was listed as having "No Role" in the 12/17/11 report. The 11/8/11 and 12/17/11 reports were unfounded.

The SM was listed as one of the subjects in the 6/23/12 report. This report included the allegations of IG, L/B/W and PD/AM and the allegations involved other household members. The report alleged the half sibling sustained scratches on her face and "no adult household member could account for what happened" to the half sibling's face. ACS substantiated the allegation of IG of the half sibling, who was then approximately 1-year-old, by the SM. ACS indicated the case on 8/6/12. ACS closed the investigation stage and the case remained open for preventive services.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Required Action(s)

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

Preventive Services History

As result of the 6/23/12 investigation, ACS found the SM and MA resided in the same home. The investigation revealed that the SM and MA did not provide adequate supervision of the children. ACS found the SM suspected the MA became angry and intentionally scratched the half sibling. ACS learned during the 6/23/12 investigation that the MA had a substance abuse issue and referred her for treatment and random drug screens. ACS referred the MA to parenting, anger management, education classes, daycare and Early Intervention. ACS opened the Family Services stage, on 7/18/12 and the family received PPRS. On 7/18/12 the family engaged in preventive services with the New York Foundling Mott Haven Preventive Agency. The family received services to address adult supervision of the children who resided in the home. The case planning agency documented that the family complied with the service plan and the family's needs were met. The case planning agency conducted monthly home visits and observed the children in the home who appeared to be well. The Family Services Stage was closed on 8/12/13.

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