Child Fatality Report

Report Identification Number: NY-17-071

Prepared by: New York City Regional Office

Issue Date: Jan 08, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 07/10/2017
Initial Date OCFS Notified: 07/10/2017

Presenting Information

The SCR registered a report alleging the mother found the SC dead on her bed (SC) at 7:45 A.M. on 7/10/17. The report stated the death of the SC was deemed suspicious as there was bruising on the left side of her spine and the left side of her head. It was also alleged the SC had bite marks on her back and upper chest.

The report noted the mother had seen the SC at 2:00 A.M. when she went to check the SC. The report also noted the SC had no pre-existing condition.

Executive Summary

The family was known to the SCR and ACS in two reports registered by the SCR on 4/7/15 and 3/16/17. The 4/7/15 report was indicated for IG of the 5-year-old SS by the father who physically assaulted the mother in the SS's presence. The mother was pregnant with the SC and left NYS due to issues related to domestic violence. The 3/16/17 report was assigned to the Family Assessment Response (FAR) team for concerns of EdN of the 5-year-old SS.

The SC died on 7/10/17. The autopsy report listed the cause of death as interstitial pneumonia and acute hepatitis in the setting of viral infection (adenovirus, human rhinovirus/enterovirus, and parainfluenza virus) and klebssiella sepsis, and the manner of death as natural.

The SCR registered a report concerning the SC's death on 7/10/17 with allegations of DOA/FATL, L/B/W and IG of the SC by the mother, the PS (father of the 5-month-old SS) and his brother. ACS determined the PS's brother was not a person legally responsible for the SC. At the time of the fatality, the family had an open PPRS case with the Jewish Child Care Association (JCCA).

According to the case documentation, the mother stated the SC was asleep on her toddler bed and when she checked the SC at 7:45 A.M., the SC was unresponsive. The family called 911;EMS declared the SC dead. The 5-year-old SS was visiting her father at the time of the incident.

ACS initiated the investigation timely and contacted family members at the CAC. ACS documented the SC had unexplained bruises on her body and a bite mark. The mother said the bite mark was inflicted by the 5-year-old SS. Neither the mother nor the PS could specify how the SC sustained the bruises. ACS observed the interview with the SS at the CAC, but not the interview with the adults. The SS disclosed the mother hit her on her buttocks with a belt and used her hand to hit her (the SS) on her mouth. The SS also disclosed she had witnessed violence between her parents. The physician at the CAC examined both SS and found no marks or bruises indicative of abuse or maltreatment.

ACS conducted an emergency removal of the two SS from the care of the adults. According to ACS' documentation, the removal was based on the SC's unknown cause of death. ACS filed an Article 10 Petition of Neglect at the Kings County Family Court (KCFC) naming the mother and the PS as the respondents. The SS were temporarily remanded and placed in the custody of ACS' Commissioner. ACS granted the mother and the PS a supervised visit at the Children's Center on 7/11/17. They were observed by ECS' staff to be appropriate with, and concerned about the siblings.

On 7/13/17, ACS held a Child Safety Conference (CSC) and returned to the KCFC on 7/14/17. The 5-year-old SS was released to her father and the 5-month-old SS was placed in a non-kinship home under the auspices of Sheltering Arms.

Later, on 8/14/17, the 5-month-old SS was transferred to a kinship home.

The investigative documentation of the safety assessments and the risk assessment profile were approved although inconsistent with case information.

ACS contacted the ME and learned the SC's death was natural. The case documentation did not reflect a discussion regarding plans to return the SS to the mother and the PS. The SS remained in the respective homes approved by ACS. When asked about the basis for the continued placement, ACS indicated a review of the autopsy report determined unanswered injuries (contusions, abrasions and scars) on the SC's body which suggested physical abuse and while the OCME would not conclusively say physical abuse took place, they did say it could not be ruled out. ACS explained that continued foster care placement appeared to be warranted. ACS also noted the prior medical recommendations were not followed for the SC to return to the hospital if symptoms continued. The SC was underweight at death and had pneumonia and sepsis.

On 11/2/17, ACS indicated the report.

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?** No
  - **Safety assessment due at the time of determination?** No
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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?** Unable to Determine

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The documentation did not clearly state the risk or safety factors that placed the siblings in immediate and imminent danger of serious harm to warrant a removal.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	ACS did not utilize the information gathered to select an accurate safety decision or safety factors.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality 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 24 Hour Assessment
Summary:	ACS did not utilize the information gathered to select an accurate safety decision or safety factors. The siblings were removed; however, there was no evidence of immediate danger of serious harm documented.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality 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 Risk Assessment Profile (RAP)
Summary:	The Risk Assessment was not adequately completed for this family.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality 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:	Appropriateness and adequacy of child's foster care placement
Summary:	ACS filed an Article 10 Neglect Petition based on not knowing the cause of death of the SC. However, after learning the SC died of natural causes ACS took no action to return the siblings.
Legal Reference:	18 NYCRR 430.11(c) or (d)
Action:	ACS must meet with the staff involved in this fatality 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:	The supervisory reviews did not reflect the information gathered from collaterals was utilized when making decisions and accessing safety and risk.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)
Action:	ACS must meet with the staff involved in this fatality 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:	Appropriateness of allegation determination
Summary:	The documentation did not support ACS' decision to substantiate the allegation of Inadequate Guardianship of the SC by the mother and PS.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:	ACS must meet with the staff involved in this fatality 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/10/2017 **Time of Death:** 08:17 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:00 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 6 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

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

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	20 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	20 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Month(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Other Household 2	Father	No Role	Male	27 Year(s)

LDSS Response

ACS made contact with the family and assessed the home timely. According to the home assessment and service providers, there were no safety concerns present. All the children had appropriate sleeping arrangements and other provisions. In addition, the JCCA CP's documentation of progress notes repeatedly indicated there were no visible marks or bruises on the children.

The mother and the PS reported that on 7/9/17, after dinner, the SC began to vomit and had diarrhea. The mother cleaned the SC and stayed up until 2:00 A.M. when the SC fell asleep. The mother checked the SC at 7:45 A.M. and found the SC was unresponsive. The mother said the SC was cold, her face was purple and her hands were "up in a fist." The mother called 911 and attempted to administer CPR as instructed by the operator, but was unsuccessful. According to the mother, the SC had a medical appointment on the morning of her (the SC's)death.

ACS learned the SC had a medical condition, and had been admitted at Maimonides Hospital twice in June. ACS interviewed several physicians who treated the SC at the hospital, and a hospital SW. None had concerns about the mother's ability to care for the SC. On both occasions, the SC was stabilized and released to the mother. The cause of the SC's presenting symptoms was unknown. It was recommended that the SC be treated as an out-patient.

The SC was seen at the hospital on 7/3/17, the physician noted the SC was observed to have a bite mark on her back; which appeared to be consistent with a child's bite. This information was consistent with the explanation the mother gave ACS. ACS did not re-interview the CP regarding this information.

ACS noted that after one of the SC's discharge, the mother received instructions to return to the hospital, if the SC began to vomit or have diarrhea. ACS documented the mother failed to take the SC to the hospital on 7/9/17. ACS did not explore this matter with the medical collateral contacts to determine if a few hours delay could have caused the SC's death. However, based on the information gathered the mother was not known to miss medical appointments for the SC.

Other medical providers noted the children were receiving appropriate medical care and expressed no concerns of child abuse or neglect.

Prior to returning to KCFC on 7/14/17, ACS made sufficient relevant collateral contacts to assess the siblings' safety in the care of the mother and the PS. Based on the family's history and the information gathered from service providers, there was no indication the siblings were in immediate or impending danger of serious harm. In addition, no allegations were added for the siblings. ACS did not document any other reason for the removal of the siblings except for the SC's unknown cause of death. Although the mother's history with ACS consisted only of the FAR, and the PS had no CPS history, ACS did not consider COS for the siblings.

On 9/29/17, the ME stated the SC's case was shared with many other specialists and they all concluded that it was "99% a natural death". The ME ruled out child abuse and explained some of the SC injuries. The ME stated the SC was very sick and there were underlying conditions from birth which were possibly never discovered.

On 11/2/17, ACS indicated the report.

On 12/26/17, ACS noted a review of the autopsy report determined unanswered injuries (contusions, abrasions and scars) on the SC's body. ACS determined these injuries suggest physical abuse although the OCME would not conclusively say physical abuse took place, they did say it could not be ruled out. ACS explained that "continued foster care placement appears to be warranted." ACS noted the prior medical recommendations for the child to return to the hospital if symptoms continued were not followed. The SC was underweight at death and had pneumonia and sepsis.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039554 - Deceased Child, Female, 20 Month(s)	039555 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
039554 - Deceased Child, Female, 20 Month(s)	042861 - Mother's Partner, Male, 20 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
039554 - Deceased Child, Female, 20 Month(s)	039555 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
039554 - Deceased Child, Female, 20 Month(s)	042861 - Mother's Partner, Male, 20 Year(s)	DOA / Fatality	Unsubstantiated
039554 - Deceased Child, Female, 20 Month(s)	042861 - Mother's Partner, Male, 20 Year(s)	Inadequate Guardianship	Substantiated
039554 - Deceased Child, Female, 20 Month(s)	039555 - Mother, Female, 26 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
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?	☐	☒	☐	☐
Explain: The siblings were removed from the home; however, the documentation did not support the safety decision as the immediate and imminent danger of serious harm was not reflected in the investigation. ACS contacted relevant collaterals, but did not utilize the information to assess the safety concerns for the siblings.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
ACS removed the siblings although prior to seeking court intervention they were medically cleared by the CAC physician. Also, none of the collateral contacts mentioned any concerns about the safety of the children.

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:**
07/10/2017	There was not a fact finding	There was not a disposition
Respondent:	039555 Mother Female 26 Year(s)	
Comments:	Based on the initial reports prepared for Family Court, the siblings were removed solely on the SC's unknown cause of death. The documentation did not reflect the information gathered concerning the ME's findings was presented in Family Court to reconsider the option of COS. It is unclear how ACS presented the siblings' were in imminent danger of serious harm as none of the collaterals presented any concerns. Other than the father of the 5-year-old sibling, the subject parents had no CPS history.	

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	☐	☐	☐	☐	☐	☒	☐

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:
ACS assessed the siblings were in imminent danger of serious harm and removed the surviving siblings. The children were placed in care. The documentation did not reflect any additional services for the children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief counseling services were offered.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

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)
03/16/2017	Sibling, Female, 5 Years	Mother, Female, 26 Years	Educational Neglect	Far-Closed	No

Report Summary:
The 5-year-old sibling was absent from school 45 times and was failing academically. The report alleged the mother was aware of this matter and did nothing to address this issue.

The mother had just given birth and had another child to care for (SC) which made it difficult to take the 5-old-year-sibling to school. The mother also reported the 5-year-old sibling had lice and was kept home for several days. ACS confirmed the mother had limited resources to help with the children and referred the family for services.

OCFS Review Results:
The reportwas appropriately assigned to the FAR track based on the allegation criteria of the report.

FAR referred the SC to Early Intervention, provided daycare vouchers where provided for the SC and sibling, the family was link to PPRS.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/07/2015	Sibling, Female, 3 Years	Other - Sibling's Father, Male, 27 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Female, 3 Years	Other - Sibling's Father, Male, 27 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:
The SCR registered a report alleging the parents of the 3-year-old sibling had engaged in incidents of domestic violence in the presence of the sibling. The report noted during an incident in March 2015, the father was intoxicated and assaulted the mother. The investigation revealed the mother fled with the sibling and stayed with a friend, but returned to the home due to not having financial resources. During the investigation, ACS provided numerous resources for the mother to address safety concerns (DV). However, the mother decided to return to Texas to stay with the MGM.

The mother was pregnant with the SC.

Determination: Indicated **Date of Determination:** 06/15/2015

Basis for Determination:
ACS substantiated the allegation of IG and Unsubstantiated the allegation of Parent Drug/Alcohol Misuse of the SC by the father.

ACS based their decision of the IG allegation on the parents' admission of the domestic violence incidents. The decision to unsubstantiate the allegation of Parent Drug/Alcohol Misuse was based on ACS' observation which noted the father was never seen under the influence of any substance.

OCFS Review Results:
The investigation revealed that ACS did not thoroughly assessed the safety of the sibling as it related to DV. ACS did not complete the local protocol. Instead, ACS planned with the parents on having the father pay for the mother to return to Texas. The 7-day safety assessment was not completed appropriately. The comments for the safety factors selected did not detail how the caretakers behavior impacted the sibling's safety.

ACS did not issue the NOI to the parents.

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

Issue:
Failure to Provide Notice of Indication
Summary:
The Notice of Indication was not issued to the parents.
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:
Timely/Adequate Seven Day Assessment
Summary:
ACS selected the safety decision and safety factors relevant to the family's circumstances. However, did not support how the safety factors impacted on the parents' ability to care for the sibling.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this fatality 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.

[redacted]

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

The family had no CPS history during this period.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 03/22/2017

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

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: Sheltering Arms Mixed				

Preventive Services History

At the time of the fatality, the family had an open ADVPO case with the JCCA/CPP dated 3/22/17. ACS referred the family for preventive services as a resulted of a Family Assessment Response (FAR).

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