Child Fatality Report

Report Identification Number: NY-17-148

Prepared by: New York City Regional Office

Issue Date: May 22, 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: 2 day(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 12/17/2017
Initial Date OCFS Notified: 12/18/2017

Presenting Information

The OCFS Form-7065 stated that the infant was born prematurely (27 weeks) in December 2017. The BM experienced complications during pregnancy. The infant remained in the hospital from birth until his death. On 12/17/17, the infant died as a result of a medical condition.

Executive Summary

This newborn infant died on 12/17/17. The infant was born prematurely at 27 weeks gestation and following his birth, he remained hospitalized until the time he was pronounced dead. The infant was never released to the BM's care. ACS obtained information from the hospital and verified the infant died due to natural causes. The infant was pronounced dead by the attending physician.

At the time of the infant's death, the family had an open investigation that began on 12/15/17. ACS initiated the investigation in a timely manner and found the BM gave birth to the infant in the hospital and both the BM and infant received medical care for treatment of serious illnesses. The BM tested positive for marijuana at the time she gave birth to the infant but the infant had a negative toxicology. The BF visited the hospital and provided the necessary support to the BM. The four surviving half-siblings were in the care of resource relatives. On 12/18/17, ACS learned that the infant passed away at approximately 3:00 PM on 12/17/17. The BM signed herself out of the hospital against medical recommendation on 12/17/17.

ACS submitted the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Cases.

The ACS Specialist visited the home, interviewed the BM and BF and assessed safety of the 9-year-old half-sibling on 12/18/17. The BM said her family would assist with burial arrangements. ACS addressed the issue of the BM's drug use. The BM acknowledged she used marijuana during her pregnancy and while supervising the 2-year-old and 9-year-old half-siblings. The BF denied drug/alcohol use but admitted he was aware the BM smoked marijuana. ACS did not assess safety of the three other half-siblings within 24-hours of notification of the infant's death as these children were not in the BM's home. The documentation reflected the 2-year-old male was in the temporary care of an aunt, 11-year-old female resided with her father (with whom the BM had shared custody) and the 12-year-old male was in the custody of his godmother.

ACS opened a service case on 12/19/17 and referred the family for PPRS on 1/17/18. The Leake and Watts agency had case planning responsibility. The BM submitted to random drug testing, her test results were positive for marijuana and she was referred to a substance misuse program. She was compliant with the service plan implementation. The BF did not make himself available for services. The family received counseling, monitoring of substance abuse treatment, housing, health and education needs, and referral for Early intervention.

As of 5/15/18, the case remained open for PPRS.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
N/A

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:	Timely/Adequate 24 Hour Assessment
Summary:	ACS was notified of the infant's death on 12/18/17; however, the agency did not assess safety of all the surviving half-siblings within 24 hours of notification of the infant's death.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/17/2017 **Time of Death:** 03:00 PM

County where fatality incident occurred: Bronx

Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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: Hospitalized

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	2 Day(s)
Deceased Child's Household	Father	No Role	Male	34 Year(s)
Deceased Child's Household	Mother	No Role	Female	31 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Other Household 1	Sibling	No Role	Female	11 Year(s)
Other Household 2	Sibling	No Role	Male	12 Year(s)

LDSS Response

ACS interviewed hospital staff regarding the infant's death on 12/18/17. ACS learned that the attending physician listed the cause of death as a medical condition and the manner as natural. ACS noted the BM had a life threatening medical condition that required emergency delivery of the infant and the infant was born prematurely. The BM said she received pre-natal care and she provided contact information for her physician; however, it was determined that the physician had not provided pre-natal care to the BM during her pregnancy with the infant.

During an ACS home visit that occurred on 12/18/17, the BM discussed her illness, hospitalization and other actions regarding the infant. The BM's explanation was consistent with information that was previously provided by hospital staff. The BM refused burial assistance for the infant but accepted referral for PPRS including bereavement counseling. She said she smoked marijuana prior to the time ACS arrived in the home but after the 9-year-year old half-sibling went to school on 12/18/17. ACS staff counseled the BM about the hazards of using marijuana while caring for children.

The BF told ACS staff that he was aware of the BM's marijuana use and he said he did not use substances. He assisted the BM with care of the 2-year-old and 9-year-old half-siblings. ACS noted that the BM had shared parental custody of the 9-year-old half-sibling with this child's father. ACS interviewed the 9-year-old half-sibling and addressed possible knowledge of drug/alcohol use in the home. This half-sibling did not respond to queries about the use of drugs/alcohol in the home. He also did not recall any recent visit to his father's home. The 2-year-old half-sibling was not at home as he

was in the temporary care of his father during the 12/18/17 home visit.

ACS Specialist observed the 12-year-old male half-sibling in his godmother's home on 2/8/18. The documentation did not clarify whether ACS reviewed official custody records for the 12-year-old male half-sibling. ACS interviewed the 11-year-old female half-sibling in school on 2/14/18. During the 2/14/18 interview, this half-sibling said she wanted to reside with the BM. ACS staff counseled the female half-sibling regarding housing issues and family arrangement.

ACS requested a Credential in Alcohol and Substance Abuse Counseling (CASAC) assessment for the BM, and EI for the 2-year-old half-sibling on 1/17/18 and 1/22/18, respectively. On 1/26/18, ACS received results of random drug screening for the BM and noted the BM tested positive for marijuana. The CASAC consultant referred the BM for ongoing substance abuse treatment. The BM signed an agreement for PPRS with the Leake and Watts Services, Inc. agency, Family Treatment Rehabilitation program on 2/28/18.

During the period from 3/1/18 through 4/16/18, the Leake and Watts Services, Inc. agency CP visited the home and 9-year-old half-sibling's school. The CP observed the 2-year-old and 9-year-old half-siblings in the BM's home and noted these children did not have visible marks/bruises. The BM was observably alert and there was no indication she was under the influence of drugs or illicit substances. The BM received in-home drug screenings and the results were positive for marijuana. On 4/9/18, the BM attended an intake appointment for drug treatment program. The family maintained a stable housing condition and resource relatives provided emotional and financial support. The BM complied with service plan implementation but the BF did not make himself available for services. As of 5/15/18, the case remained open for PPRS.

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: Hospital physician

Multidisciplinary Investigation/Review

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.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

N/A

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 infant had four surviving half-siblings. ACS assessed safety of the 9-year-old male half-sibling within 24 hours of notification of the infant's death. ACS staff observed the other three half-siblings on 12/28/17, 2/8/18 and 2/14/18, respectively; however, the safety assessments were incomplete as a ACS did observe the home conditions of the father of the 9-year-old and godmother of the 11-year-old half-siblings.				

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: N/A				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

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: The family received PPRS.							

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 family received PPRS including: Early Intervention screening, case management and monitoring of education and health needs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The BM received counseling, random drug screening and referral for drug treatment services. The BF did not make himself available for services.

History Prior to the Fatality

Child Information

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

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)
12/15/2017	Sibling, Male, 9 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Indicated	Yes
	Deceased Child, Male, 2 Days	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Indicated	

Sibling, Male, 2 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Indicated
Deceased Child, Male, 2 Days	Mother, Female, 31 Years	Inadequate Guardianship	Indicated

Report Summary:
The 12/15/17 SCR report alleged the BM gave birth to a male infant in December 2017. The BM tested positive for marijuana.

Determination: Indicated | **Date of Determination:** 02/16/2018

Basis for Determination:
ACS substantiated the allegations of IG of the infant and PD/AM of the infant and 2-year-old and 9-year-old half-siblings on the basis that the BM tested positive for marijuana at the time she gave birth to the infant. ACS explained that the BM misused marijuana during her pregnancy, tested positive for marijuana after she gave birth to the infant and admitted to smoking marijuana at least once per day in the home where the half-siblings resided. CASAC recommended that the BM attend drug rehabilitation on a daily basis but the BM had not been attending the program.

OCFS Review Results:
ACS initiated the investigation within 24 hours of receipt of the 12/15/17 report. ACS found the BM tested positive for marijuana at the time she gave birth to the infant. The infant tested negative for all substances. ACS observed the infant and BM in the hospital and noted they were both very ill. The infant remained in the hospital until the time he was pronounced dead. ACS staff interviewed the BF at home on 12/15/17. The BF provided details of family support and plans for the family.

ACS assessed home conditions, provided safe sleep education and monitored the BM's marijuana use. ACS did not assess the impact of the BM's marijuana use on the care she provided the half siblings.

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

Issue:
Failure to Provide Notice of Indication

Summary:
ACS did not provide Notice of Indication to the BF who was listed in the household composition during the 12/15/17 investigation.

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

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Appropriate Application of Legal Standards (Abuse/Maltreatment)

Summary:
ACS substantiated the allegations of IG and PD/AM of the infant by the BM. ACS did not appropriately apply the standards of maltreatment to the case circumstances as the infant was hospitalized following his birth and remained in the hospital until the time of his death. The BM did not provide care of the infant as the infant had not been released to her care.

Legal Reference:
SSL 412(1) and 412(2)

Action:

ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/21/2017	Sibling, Female, 10 Years	Other Adult - Father of half-sibling, Male, 32 Years	Inadequate Guardianship	Unfounded	Yes
	Other Child - Child residing in household, Male, 12 Years	Other Adult - Father of half-sibling, Male, 32 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 5/21/17 SCR report alleged the father of the female half-sibling physically abused a male child, pushed him, hit him with metal objects and shoved him to the ground. It was unknown if the male child sustained injuries as a result of the maltreatment. The female half-sibling witnessed this abuse and became scared. The father threatened to do the same to her. The other child and mother had unknown roles.

Determination: Unfounded | **Date of Determination:** 07/24/2017

Basis for Determination:
ACS unsubstantiated the allegation of IG of the male child and female half-sibling named in the 5/21/17 report. ACS noted that all the children denied the parents used physical discipline as a form of punishment. ACS added that the children did not have observable marks or bruises.

OCFS Review Results:
ACS visited the BM and father's households and found the children had no visible marks/bruises and there were no children in immediate or impending danger. ACS learned that the father hit the male child to address the child's misbehavior. The BM and father had history of DV, engaged in threatening disputes, the BM made arrangements for substitute caregivers to care for her children and BM and father failed to demonstrate developmentally appropriate expectations of the children. ACS did not obtain details about family's disputes. The household composition was not updated. ACS did not enter progress notes contemporaneously as events occurred on 5/22/17 but were not entered until 7/24/17.

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

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
ACS did not review case history or obtain adequate information to address the custody/visitation concerns that were revealed during the 5/21/17 investigation. ACS did not update household composition information to accurately reflect each household member's address.

Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

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

Summary:
ACS completed a RAP and assigned a Final Risk Rating of "Low" to the case; however, the RAP did not include accurate responses to the elements pertaining to: child in RAP family unit in the care or custody of substitute caregiver,

BM and father of half-sibling as victim or perpetrator of threatening incidents and caretakers' demonstration of developmentally appropriate expectations of children.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

ACS did not enter the Investigation Progress Notes contemporaneously as several events occurred on 5/22/17 but were not entered until 7/24/17.

Legal Reference:

18 NYCRR 428.5(a) and (c)

Action:

ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/01/2017	Sibling, Male, 1 Years	Father, Male, 37 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 1 Years	Father, Male, 37 Years	Swelling / Dislocations / Sprains	Unfounded	
	Sibling, Male, 1 Years	Father, Male, 37 Years	Lacerations / Bruises / Welts	Unfounded	
	Sibling, Male, 1 Years	Father, Male, 37 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 1 Years	Father, Male, 37 Years	Excessive Corporal Punishment	Unfounded	

Report Summary:

The 4/1/17 SCR report alleged that on a daily basis, the father of the 1-year-old male half-sibling drank alcohol and smoked marijuana while being the sole caregiver of the male half-sibling. The father became intoxicated and was unable to care for the male half-sibling. On an ongoing basis, the father used excessive force while punishing the half-sibling. He hit the half-sibling on the arms and legs with his hands causing bruising. On 4/1/17, he became angry and out of control and grabbed the half-sibling by pulling him into a piece of furniture causing the child to hit his head. The half-sibling sustained a swollen lump as a result. The roles of the grandparents and BM were unknown.

Determination: Indicated | **Date of Determination:** 05/18/2017

Basis for Determination:

ACS substantiated the allegation of PD/AM of the male half-sibling by the father on the basis that he admitted he used marijuana. The father refused a drug screen and treatment intervention when suggested by ACS. ACS explained that the half-sibling resided with the BM.

ACS unsubstantiated the allegations of XCP, IG, L/B/W and S/D/S of the half-sibling by the father on the basis that ACS staff observed the half-sibling within 24 hours of notification of the 4/1/17 report and found the half-sibling did not have marks/bruises or injuries. ACS explained that the BM said the half-sibling resided with her and was never left alone in the father's care.

OCFS Review Results:
ACS observed the male half-sibling, father and PGM in the father's home on 4/1/17 and BM's home on 4/3/17. The father and PGM denied the father hit the half-sibling. The father admitted he used marijuana. The family had a crib, food and other supplies for the half-sibling. ACS Specialist observed the half-sibling's body and found he did not have marks/bruises.

The older half-sibling was not observed until 4/3/17. ACS obtained school records, found the older half-sibling had 36 absences and addressed the school transfer needs. ACS requested additional records from school, Dr., and Early Intervention program; the information was not documented during the 4/1/17 investigation.

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

Issue:
Appropriate Application of Legal Standards (Abuse/Maltreatment)

Summary:
ACS did not appropriately apply the standards of maltreatment to the case circumstances. ACS substantiated the allegation of PD/AM of the older male half-sibling by the father; however, the agency did not include findings of the impact of the subject father's drug use on the care he provided the subject child.

Legal Reference:
SSL 412(1) and 412(2)

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Failure to Provide Notice of Indication

Summary:
ACS did not provide Notice of Determination to the father who was listed as a subject and to the BM and grandparents who were the "other persons" listed in the 4/1/17 report.

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

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/04/2015	Sibling, Male, 7 Years	Mother, Female, 26 Years	Educational Neglect	Unfounded	Yes

Report Summary:
The 5/4/15 SCR report alleged the 7-year-old male half-sibling was absent 37 days during the 2014-2015 academic year and was failing as a result. The report also alleged the BM was aware of the issue and had failed to ensure the half-sibling attended school.

Determination: Unfounded | **Date of Determination:** 07/02/2015

Basis for Determination:
ACS unsubstantiated the allegation of EdN of the half-sibling by the BM on the basis that there was no credible evidence to justify the BM had not attended to the half-sibling's educational and medical needs.

OCFS Review Results:
ACS attempted to visit the home on 5/4/15 and found the family had relocated. On 5/5/15, ACS staff interviewed the half-sibling in school and noted he appeared to have received adequate care. The Specialist interviewed the BM who acknowledged the half-sibling had absences from school due to illness and family relocation. The Specialist participated in a school conference on 6/2/15 and learned that the half-sibling's attendance had improved. The half-sibling was promoted in school.

ACS did not conduct adequate investigative activities to assess the home conditions for three half-siblings, fathers, resource relatives, history of domestic violence, and to update household compositions.

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

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
ACS did not conduct adequate investigative activities to assess the home conditions for the three of the four half-siblings, fathers' level of involvement, resource relatives, family history of domestic violence, and did not update the household compositions.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
During the 5/4/15 investigation, ACS noted the BM had four children; however, ACS only completed a safety assessment of the male half-sibling who was the subject child in 5/4/15 report. ACS observed another male-half sibling while he visited the BM's home but did not observe this child's custodial parent's home condition. There was no effort to observe two of four the half-siblings.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
ACS inappropriately completed the RAP as the document did not include information about the Secondary Caretaker, and BM and other caretaker's history of DV and willingness to address DV concern.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/08/2014	Aunt/Uncle, Male, 14 Years	Mother, Female, 28 Years	Excessive Corporal Punishment	Unfounded	Yes
	Aunt/Uncle, Male, 14 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded	
	Aunt/Uncle, Male, 14 Years	Grandparent, Female, 52 Years	Excessive Corporal Punishment	Unfounded	
	Sibling, Female, 8 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 8 Years	Grandparent, Female, 52 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 9 Years	Mother, Female, 28 Years	Sexual Abuse	Unfounded	
	Other Child - Not Reported, Female, 1 Years	Mother, Female, 28 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 6 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 6 Years	Grandparent, Female, 52 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 8 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 9 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 9 Years	Mother, Female, 28 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 9 Years	Grandparent, Female, 52 Years	Lack of Supervision	Unfounded	
	Other Child - Not Reported, Female, 1 Years	Grandparent, Female, 52 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 6 Years	Mother, Female, 28 Years	Lack of Supervision	Unfounded	
	Aunt/Uncle, Male, 14 Years	Mother, Female, 28 Years	Sexual Abuse	Unfounded	
	Aunt/Uncle, Male, 14 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Unfounded	
	Aunt/Uncle, Male, 14 Years	Grandparent, Female, 52 Years	Sexual Abuse	Unfounded	
	Sibling, Female, 8 Years	Mother, Female, 28 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 9 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 9 Years	Grandparent, Female, 52 Years	Sexual Abuse	Unfounded	

Other Child - Not Reported, Female, 1 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded
Other Child - Not Reported, Female, 1 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 6 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Unfounded

Report Summary:
The 12/8/14 SCR report alleged that two years prior to 12/8/14, the BM and MGM beat the 14-year-old MU because he put his penis in unknown sibling's mouth. The report also alleged the BM and MGM left the MU to supervise the half-siblings. The MU smacked a younger half-sibling, attempted to burn him with a lighter and tried to cut his leg with a knife. The male half-sibling started a fire in the home in November 2014 and it was unknown who was supervising him at the time.

Determination: Unfounded **Date of Determination:** 02/06/2015

Basis for Determination:
ACS unsubstantiated the allegations of XCP, IG, LS and SA on the basis of finding no credible evidence. ACS explained that the children and all family members denied there had been inappropriate sexual behavior in the family. The children did not have observable marks or bruises.

OCFS Review Results:
ACS and LE conducted joint interviews with household members on 12/9/14. ACS verified the half-sibling, who was then six years old, set fire to a mattress. LE provided Fire Intervention Program service; however, ACS did not discuss the outcome of the service. The half-siblings, MU and caretakers denied use of corporal punishment and sexual abuse in the family. ACS Specialist observed two half-siblings and MU in school and at home and found they did not have visible marks or bruises. The BM and a 6-year-old half-sibling had unstable housing and they relocated in February 2015.

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

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
The 12/8/14 investigation was incomplete as ACS did not visit the home of the 14-year-old MU. The allegation stated the MU put his penis in a half-sibling's mouth; however, the interviews were insufficient to assess the the extent of parental control at the time of the alleged incident.

Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Face-to-Face Interview (Subject/Family)

Summary:
The documentation did not establish whether ACS interviewed the MGM who was an alleged subject of the 12/8/14 investigation.

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

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
The case recording was inadequate as ACS did not update the household composition to reflect the accurate identifying information/date of birth for the MGM.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

[redacted]

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

The family was known to the SCR and ACS in three reports dated 8/3/10, 9/13/10 and 1/10/14.

ACS consolidated the 8/3/10 and 9/13/10 reports and conducted one investigation. These reports included the allegations of IF/C/S, IG, LS and PD/AM of half-siblings and other children in the household by the BM and other caretakers. On 10/1/10 ACS unsubstantiated the allegations pertaining to the BM and substantiated the allegations of LS, IG and PD/AM by the other caretaker. The 8/3/10 report was indicated and closed. ACS referred the family to community based services.

The 1/10/14 report included IG of a 5-year old half-sibling by the father. ACS unsubstantiated the allegation on the basis of finding no credible evidence. ACS closed the case utilizing closure reason - "No services required."

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

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?	☒	☐	☐	☐

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