Child Fatality Report

Report Identification Number: NY-18-012

Prepared by: New York City Regional Office

Issue Date: Jul 31, 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: 5 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 02/07/2018
Initial Date OCFS Notified: 02/07/2018

Presenting Information

The 2/7/18 report alleged that on 2/6/18, the SC had an asthma attack earlier in the day. At 11:22 PM, the SC was found on the bathroom floor in cardiac arrest. Emergency services were called and CPR was attempted. The SC was taken to the hospital where he was pronounced dead on 2/7/18. It was unknown whether the SC's guardian and parent substitute took all the necessary and appropriate steps to ensure the SC's well-being; therefore, his death was considered suspicious.

The 2/9/18 report alleged that on 2/7/18, the SC died for unknown reasons in the care of the SM. The SM had been beating the SC, 6-yo-CH, and 3-yo-CH for their entire lives. The SM became frustrated with the CHN and used excessive physical force while beating them. All the CHN had sustained bruises as a result. Due to the SM's history of violence toward the CHN, the SC's death was suspicious. On an unknown date, the 3-yo-CH sustained two broken legs in the SM's care.

Executive Summary

The 5-year-old male child (SC) died on 2/7/18. The autopsy listed the cause of death as Acute and Chronic Bronchial Asthma and the manner of death as natural.

The allegations of the 2/7/18 report were DOA/Fatality and IG of the SC by the guardian and parent substitute (PS). A report was registered on 2/9/18. The allegations of the 2/9/18 report were DOA of the SC, IG and L/B/W of the SC, 3-yo-female HS and 6-yo-female half sibling (HS), and FX of the 3-yo by the SM.

ACS learned that on 2/6/18 the SC had difficulty breathing. According to the guardian, on 2/6/18, the SC awoke at 7:45 AM and she gave him an asthma Tx. At about 9:00 AM, he spoke with the SM by phone. The guardian said the CHN did not attend school as she recently moved to Brooklyn and planned to obtain the required school transfer. At about 3:00 PM, she gave the SC another Tx. The guardian said the SC notified her whenever he was ill. After he received the Tx, he said he felt better. The guardian reported the SC acted normally, played with his siblings, watched TV and ate snacks throughout the day. At 8:30 PM, the SC told the guardian he had difficulty breathing, and she gave him another Tx. The SC did not report discomfort. At about 10:00 PM, the SC complained he had difficulty breathing and she gave him another Tx. At about 11:15 PM, the SC told her he had to use the bathroom. She asked the PS to assist the SC in the bathroom. The PS knocked on the bathroom door and there was no answer. The PS found the SC face up on the floor. The PS alerted the guardian who entered the bathroom, observed the SC on the floor, and started CPR. The neighbor, who was visiting the home, called 911. The guardian continued to perform CPR until EMS arrived.

The CHN were removed on an emergency basis from the guardian's home. On 2/9/18, ACS filed an Article Ten Neglect petition in the Kings County Family Court, naming the SM and guardian as the respondents. A remand of the SS and HS was granted. The CHN were placed in a kinship foster home. The guardian had a 17-yo female CH who resided out of state with her father.

On 3/6/18, a conference occurred with ACS, foster care CP, and the SM. The meeting reviewed a service plan, including: parenting, clinical health evaluation, clinical health services, random drug testing, and drug treatment. SM agreed to engage in services.

The safety assessment documents dated 2/8/18 and 2/14/18 were inadequate as they included associated comments that did not support the selected safety factors. The comments regarding the guardian's clinical health and admission of drug use did not reflect whether her actions or inaction had a negative impact on the CHN's care.

On 3/27/18, ACS SUB the allegations of DOA/Fatality and IG of the SC. ACS stated that the SC died of an asthma attack on 2/7/18 while in the care of the guardian and PS. ACS added that there was some credible evidence to support the allegations.

ACS IND the 2/9/18 fatality report on 3/27/18 on the basis that the CHN reported the SM hit them and left bruises on them. The CHN said they were fearful of the SM and she was mean to them. The 3-yo-CH said the SM made her cry. The CHN said they did not want to live with the SM. The 6-yo-CH said the SM left them with numerous different people and she did not feel safe. The guardian said she knew the CHN one month prior to the time the SM left the CHN in her care. ACS did not address the allegations of FX and DOA/Fatality in the Investigation Conclusion Narrative.

A report was registered on 5/15/18. The allegation was IG of the newborn by the SM. On 7/3/18, ACS IND 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?** 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?** No, sufficient information was not gathered to determine any of the allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** No

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
NA

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 2/8/18 safety assessment was inadequate as the associated comments did not support the selected safety factors. The comments regarding the guardian's health and drug use did not reflect whether her actions had a negative impact on the CH's care.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 2/14/18 safety assessment was inadequate as the associated comments did not support the selected safety factors. The comments regarding the guardian's health and drug use did not reflect whether her actions had a negative impact on the CH's care.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The 3/26/18 safety assessment was inadequate as it included comments that did not support the selected safety factors. The comment regarding the guardian's warrant was not child welfare related and did not support the selected safety factor.
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:	The ACS documentation reflected that notes were not entered contemporaneously. Some of the events that occurred on 2/8/18 and 2/12/18 were not entered until 3/16/18.
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.
Issue:	Pre-Determination/Supervisor Review
Summary:	The 2/9/18 Investigation Conclusion Narrative did not support the SUB of the allegation of DOA/Fatality. In addition, ACS did not discuss or provide an explanation regarding the allegation of FX.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)

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/Supervisor Review
Summary:	The 2/7/18 determination Investigation Conclusion Narrative did not support the ACS decision to substantiate the allegations of DOA/Fatality of the SC.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)
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:	Appropriateness of allegation determination
Summary:	ACS did not appropriately determine the 2/7/18 report and the allegation of DOA/Fatality of the 2/9/18 report. ACS did not explain the causal relationship between the SC's death and actions/inaction of the subjects and degree of care exercised.
Legal Reference:	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:	Contact/Information From Reporting/Collateral Source
Summary:	The documentation did not reflect that ACS contacted and interviewed the EMS or CHN's physician.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/07/2018 **Time of Death:** 12:10 AM

Date of fatal incident, if different than date of death: 02/06/2018
Time of fatal incident, if different than time of death: 11:15 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown

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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	Alleged Victim	Male	5 Year(s)
Deceased Child's Household	Other - Guardian	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Other Adult - Guardian's cousin	No Role	Female	39 Year(s)
Deceased Child's Household	Other Adult - Parent Substitute	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Other Household 1	Mother	Alleged Perpetrator	Female	25 Year(s)
Other Household 2	Other Child - child of Guardian	No Role	Female	17 Year(s)

LDSS Response

On 2/7/18, the attending Dr. said rigor mortis had not set in, the SC did not have suspicious marks or bruises, but had an illness consistent with asthma.

ACS learned that at the time LE arrived at the home, the guardian was performing CPR and the home smelled of cigarettes; not marijuana. The PS had been in the home with the SC, but went outside for a few minutes. When the PS returned, he discovered the SC was unresponsive.

On 2/7/18, ACS contacted the SM to obtain her correct address. The SM said she did not want to share her address with ACS. She explained that she was not in the correct state of mind to speak with ACS.

On 2/7/18, ACS staff interviewed the guardian and obtained her account of the incident. The documentation reflected that on 2/6/18, the Tx was administered to the SC between 8:00 PM and 10 PM. The ACS staff did not clarify the timeline of events regarding the time the guardian observed the SC had difficulty breathing and the time she administered the Tx. In a follow-up interview, the guardian said she knew the CHN since July 2017. The guardian said she used marijuana in January 2018 at a party. The guardian had a 17-yo female CH who resided outside of NYS with her father.

The PS explained that the SC was never left alone. The PS said he went to the neighbor's home at about 11:15 PM, and

left the SC with the guardian. The documentation did not reflect that the PS was interviewed fully as ACS did not inquire about his parenting responsibilities concerning the three CHN.

The 6-yo CH said the SC became ill and died. She had observed him in the bathroom on the floor. This CH recalled the guardian had given the SC his medication, and then the SC felt better: the timeline was not established. The 3-yo CH said the SC did not feel well, but the guardian gave him medication. She did not see the SC in the bathroom, but she observed he was transported out of the home.

On 2/7/18, ACS interviewed the guardian's cousin and a neighbor. The cousin confirmed the accounts provided by the guardian regarding the SC's difficulty with breathing and administering the Tx's that had resulted in the SC's improved health condition. The cousin said she was in the home when the SC was found in the bathroom. The neighbor had reportedly observed the SC at about 8:00 PM and found the SC acted normal. The neighbor had been visiting the home at the time the SC was found on the floor, called 911, and then went outside to wait for EMS.

On 2/8/18, ACS placed the two surviving CHN with the Sheltering Arms foster care agency.

The BF said he last saw his CHN in the summer of 2016. He thought the CHN were living with the SM and the guardian. The BF requested that the CHN be placed with his aunt. On 2/13/18, ACS placed the two CHN in kinship foster care with the PA; the New York Foundling agency had case planning responsibility.

On 2/12/18, ACS interviewed the SM in Family Court. The SM said she needed permanent housing and could not return to reside in a shelter. She said she last saw the CHN on 2/5/18, and they seemed healthy. The SM said she had not been concerned about the SC's asthma condition. He was ill in July 2017, received treatment in the hospital and his condition was stable until January 2018. The SM said the SC had his prescribed medication and the nebulizer. She spoke with the SC on the morning he felt ill. She said he told her he used the nebulizer, but felt better. The SM informed ACS that she did not need assistance.

The 2/7/18 and 2/9/18 investigations did not reflect ACS contacted the guardian's CH or father.

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 investigations.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046485 - Deceased Child, Male, 5 Yrs	046508 - Other Adult - Parent Substitute, Male, 40 Year(s)	DOA / Fatality	Substantiated

046485 - Deceased Child, Male, 5 Yrs	046507 - Other - Guardian, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
046485 - Deceased Child, Male, 5 Yrs	046509 - Mother, Female, 25 Year(s)	DOA / Fatality	Substantiated
046485 - Deceased Child, Male, 5 Yrs	046508 - Other Adult - Parent Substitute, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
046485 - Deceased Child, Male, 5 Yrs	046507 - Other - Guardian, Female, 38 Year(s)	DOA / Fatality	Substantiated
046485 - Deceased Child, Male, 5 Yrs	046509 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
046485 - Deceased Child, Male, 5 Yrs	046509 - Mother, Female, 25 Year(s)	Lacerations / Bruises / Welts	Substantiated
046510 - Sibling, Female, 6 Year(s)	046509 - Mother, Female, 25 Year(s)	Lacerations / Bruises / Welts	Substantiated
046510 - Sibling, Female, 6 Year(s)	046509 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
046511 - Sibling, Female, 3 Year(s)	046509 - Mother, Female, 25 Year(s)	Fractures	Unsubstantiated
046511 - Sibling, Female, 3 Year(s)	046509 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
046511 - Sibling, Female, 3 Year(s)	046509 - Mother, Female, 25 Year(s)	Lacerations / Bruises / Welts	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐

Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
The documentation did not reflect whether ACS contacted and interviewed the EMS or the pediatrician.

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
On 2/9/18, ACS filed an Article Ten Neglect petition in the Kings County Family Court. The SM and guardian were named as the respondents. The CHN were placed in a kinship foster home.

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/09/2018	There was not a fact finding	There was not a disposition
Respondent:	046509 Mother Female 25 Year(s)	
Comments:	On 2/9/18, ACS filed an Article Ten Neglect petition in the Kings County Family Court. The SM and guardian were named as the respondents.	

Have any Orders of Protection been issued? Yes

From: Unknown	**To:** Unknown

Explain:
Full stay away OP was issued for the two CHN and SM against the SC's BF.

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 foster care services.

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 two surviving CHN were placed in kinship foster care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
On 3/6/18, a conference occurred with ACS, CP, and the SM. The participants discussed the service plan, including: parenting, clinical health evaluation, clinical health services, random drug testing, and drug treatment. SM agreed to engage in 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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

01/26/2018	Sibling, Female, 3 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 6 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 5 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The 1/26/18 report alleged that on at least one occasion the SM hit the SC with a belt buckle. It was unknown where the SM hit the SC or whether he had sustained injuries as a result.

Report Determination: Indicated | **Date of Determination:** 03/27/2018

Basis for Determination:
ACS SUB the allegation on the basis of some credible evidence to support the allegations. Both CHN said they did not want to live with the SM. The 6-yo-CH said the SM left them with a lot of different people, and she did not feel safe. ACS gathered information about the relationship the CHN had with the guardian. The guardian said she only knew the CHN for a one-month before the SM left them in her care. A the time the report was registered, the CHN were in the care of people with whom they did not have a relationship. The SM said her CHN could not live at her paramour's home as there was no space.

OCFS Review Results:
On 1/26/18, the SC was transported to the hospital due to difficulty breathing. The CHN were in the care of the guardian since August 2017. The guardian was aware the SC was diagnosed with asthma and had medications for the SC. The 6-yo-CH said the SM was not nice to her and hit her before. The CH said the SM told her she did not want her and she could "go in the system." On 1/29/18, the SM said she would provide the guardian with the CHN's medical insurance. She was unable to meet the CHN's needs for shelter and unwilling to enter a shelter program with the CHN. She wanted them to remain in the care of guardian. On 2/7/18, SC died.

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

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

Summary:
The 3/27/18 safety assessment was inadequate as it included comments that did not support the selected safety factors. The comments regarding the guardian's clinical health and admission of drug use did not reflect whether the guardian's actions had a negative impact on her ability to care for the CHN.

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

Summary:
The ACS documentation of the SM's interview conducted on 1/29/18 did not reflect that the allegations pertaining to hitting the SC with a belt buckle was addressed with her, and also did not address the SC's medical condition regarding his hospitalization.

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:
Contact/Information From Reporting/Collateral Source
Summary:
The 1/26/18 investigation reflected that on 2/3/18, the guardian informed ACS that the SC was in school, the school did not have the required medical document for administering medication, and the SC was sent to the ER. The ACS documentation did not reflect the school and ER attending physician were contacted to verify this information.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/06/2016	Deceased Child, Male, 3 Years	Day Care Provider, Female, 54 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 2 Years	Day Care Provider, Female, 54 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 5 Years	Day Care Provider, Female, 54 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 12/6/16 report alleged that the DC provider allowed the SM to take the 2-yo CH, SC, and 5-yo CH out of her home when the SM was impaired from drinking too much alcohol and smoking too much marijuana. The DC provider was aware that the SM was the sole caretaker of the CHN, she was unable to provide adequately for the CHN when she was intoxicated.

Report Determination: Unfounded | **Date of Determination:** 02/04/2017

Basis for Determination:
ACS UNF the report on the basis that the DC provider did not observe the SM under the influence of alcohol or marijuana at any time or when the three CHN were in her care. The CHN did not disclose seeing the SM under the influence of alcohol or marijuana.

OCFS Review Results:
The group family DC had a capacity of 10 CHN; 6 weeks to 12 years plus 2 additional school age CHN. The DC license was expected to expire on 5/11/20. The DC provider said she had not observed the SM under the influence for the three years she had been caring for the CHN. She said the CHN were usually clean and tidy, and they did not have suspicious marks or bruises. The documentation reflected that the SM admitted to smoking marijuana, but not in the presence of the CHN. She denied picking up the CHN while under the influence. On 2/3/17, the SM said she did not drink alcohol or smoke marijuana. The SC said he did not observe the SM smoke, walking in an unsteady manner or fall.

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

Issue:
Failure to provide notice of report
Summary:

ACS did not provide the Notice of Existence (NOE) for the 12/6/16 report to the DC provider, who was the subject of the report, in a timely manner as it was not provided until 2/1/17. ACS did not provide the NOE to the SM.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

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)	Allegation Outcome	Compliance Issue(s)
11/30/2016	Sibling, Female, 5 Years	Mother, Female, 24 Years	Lacerations / Bruises / Welts	Unsubstantiated	Yes
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 5 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 5 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 5 Years	Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 5 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

The 11/30/16 report alleged that a couple of months prior to 11/30/16, the SM became angry and hit the 5-yo CH in the face with a brush causing the CH to sustain a bruise on her cheek. At about the same time, the SM became angry and hit the 4-yo CH with a belt causing marks and bruises to the CH's back, buttocks, and legs. The SM rarely washed the 5-yo, 4-yo, and 2-yo CHN. As a result, the 5-yo CH had a medical condition.

Report Determination: Unfounded | **Date of Determination:** 01/27/2017

Basis for Determination:
ACS UNSUB the allegations of the report on the basis of no credible evidence.

OCFS Review Results:
ACS interviewed the SM who said she smoked marijuana once or twice a week but the CHN were not with her. She said her marijuana use did not affect her ability to care for the CHN. She denied she left the CHN unsupervised. ACS addressed the SC's asthma symptoms that were observed in school. ACS advised the SM to ensure she completed documentation so the school could administered the SC's medication. The SC had his "pump" in his pocket. She said she gave the assigned nurse the documentation, but the school provided her another form. The SM denied she hit the CHN with objects, but acknowledged she may spank them. ACS interviewed the school staff and DC provider.

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

Issue:
Pre-Determination/Supervisor Review
Summary:
The ACS Investigation Conclusion Narrative did not address the allegations of IG or PD/AM.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
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:
During the 11/30/16 investigation, the progress notes reflected the family resided in Brooklyn; however, in the CPS Investigation Summary ACS documented that the SM resided in the Bronx.
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.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS did not obtain information from relevant collateral contacts. The documentation did not reflect that ACS interviewed the SM's shelter case manager and did not address the SC's asthma condition with the school.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Timely/Adequate Seven Day Assessment
Summary:

The 12/7/16 safety assessment document was inadequate it included comments that did not support the selected safety factors. The comment regarding the SM's drug use did not reflect whether the SM's actions had a negative impact on her ability to provide care of the CHN.

Legal Reference:

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

Action:

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The 1/27/17 safety assessment document was inadequate it included comments that did not support the selected safety factors. The comment regarding the SM's drug use did not reflect that the SM's actions had a negative impact on her ability to care for the CHN.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/10/2016	Other Child - cousin, Female, 13 Years	Mother, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 3 Years	Father, Male, 22 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 1 Years	Grandparent, Female, 55 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 22 Years	Inadequate Guardianship	Substantiated	
	Other Child - cousin, Female, 13 Years	Father, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Years	Grandparent, Female, 55 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 13 Years	Grandparent, Female, 55 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

The 1/10/16 report alleged that on 1/9/16, the SM, BF, and PGM were involved in a verbal and physical altercation in the presence of the SC, the 4-yo, 2-yo, and 13-yo CHN. The SC had an asthma attack and was transported to the hospital.

There was a restraining order against the BF. The PGM allowed the BF to be in the presence of the CHN, violating the restraining order and placing the CHN at harm.

Report Determination: Indicated | **Date of Determination:** 03/22/2016

Basis for Determination:
ACS SUB the allegation of IG of the CHN by the BF on the basis that the BF visited the home knowing that he was not allowed visit the PGM's residence.

ACS UNSUB the allegation of IG of the CHN by the SM and PGM as the SM was not in the home at the time the BF arrived at the home. ACS explained that the PGM had not allowed the BF to enter the home when he knocked on the door as she had contacted LE.

OCFS Review Results:
ACS interviewed the SM, PGM and DC providers. The documentation did not reflect that the LE, EMS, BF, aunt or the 13-yo cousin were interviewed to obtain relevant details. The CHN's Dr. and CP were not interviewed. The SM denied there was an incident in the home on 1/9/16. The SM acknowledged the SC was taken to the hospital for treatment of a medical condition and was released from the hospital. The SM said she did not have an OP against the BF. The SM and CHN had an OP against the BF that expired on 2/26/16. The PGM had an OP against the BF and she had contacted LE when the BF came to her home. ACS did not provide the required NOE and NOI.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
ACS did not update the household composition to reflect the accurate address information. During the 1/10/16 investigation, the progress notes reflected the family resided in Brooklyn; however, in the CPS Investigation Summary ACS documented that the SM and the two CHN (now 6-yo and 3-yo CHN) resided in the Bronx.
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.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS did not obtain pertinent information from relevant collateral contacts. The documentation did not reflect that the LE, EMS, or the 13-yo cousin were interviewed to obtain additional information. In addition, the CHN's Dr. was not interviewed.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Failure to provide notice of report
Summary:
ACS did not provide the Notice of Existence to the subjects of the report.
Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

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 the Notice of Indication to the father of the SC.

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)	Allegation Outcome	Compliance Issue(s)
05/12/2015	Deceased Child, Male, 2 Years	Mother, Female, 22 Years	Lack of Medical Care	Unsubstantiated	Yes
	Deceased Child, Male, 2 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Months	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

The 5/12/15 report alleged that the SM was not adequately caring for the 4-yo, 2-yo and 7-month old CHN. The SM expected others to care for the CHN. The SM did not bathe, feed or tend to their needs so all the other adults were forced to prepare meals, bathe the CHN as well as feed them and take care of them. If others did not prepare the meals, then the SM did not feed the CHN and they were hungry, and asked others for food. The SC was diagnosed with a medical condition and was prescribed medical care. SM failed to follow medical recommendations.

Report Determination: Unfounded | **Date of Determination:** 07/13/2015

Basis for Determination:

ACS observed the SM provided a minimum degree of care to the CHN. The CHN were well groomed and did not have marks/bruises. The CHN attended DC on a regular basis. There was an adequate supply of food in the home. ACS contacted hospital staff and verified that the SM attended the appropriate follow-up appointments for the SC. ACS found that the SM had ensured the SC received appropriate care by a medical specialist. ACS observed the SC's medical condition had improved.

OCFS Review Results:

On 5/12/15, the SM denied the allegations of the report. The SM said she followed the DR's instructions and applied the SC's medication as directed. The SM demonstrated the method she had used to apply the medication, and she provided a copy of the medical documentation. Regarding the housing status, the SM said her goal was to find her own apartment as she was in the shelter system and had a bad experience. ACS interviewed the PPRS agency and found there were no concerns regarding the well being of the CHN in the SM's care. The PPRS agency noted the family had adequate food, and the CHN were well groomed and did not have marks or bruises. ACS did not update the family address information.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
ACS did not update the case record to reflect the accurate address information. During the 5/12/15 investigation, the progress notes reflected the family resided in Brooklyn; however, in the CPS Investigation Summary, ACS documented that the SM resided in the Bronx.

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)	Allegation Outcome	Compliance Issue(s)
04/23/2015	Other Child - child of Guardian, Female, 14 Years	Mother, Female, 36 Years	Educational Neglect	Unsubstantiated	Yes
	Other Child - child of Guardian, Female, 14 Years	Mother, Female, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - child of Guardian, Female, 14 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 4/23/15 report alleged that there was no food in the home for the 14-yo CH to eat, as a result the CH was going without food and was always hungry. The CH was not attending school and had not been in school since September 2014. The CH was not getting an education as a result. The guardian was aware but failed to see that the CH went to school. The CH did not have clothes, shoes and books for school as the guardian did not provide the CH with any supplies.

Report Determination: Unfounded **Date of Determination:** 05/13/2015

Basis for Determination:
The investigation revealed that the CH resided outside of NYS with the grandmother since the guardian was incarcerated for nine years. The guardian lived with her sister and was looking for an apartment before going to court to obtain full custody of the CH. ACS contacted an out of state agency and verified information regarding the family.

OCFS Review Results:
On 4/24/15, the guardian was interviewed and she said her daughter resided with the grandmother outside of NYS. Her CH was living with the grandmother since 2004. She had joint custody with the grandmother. She said she had been incarcerated for nine years and was on probation. She was mandated by court to complete a drug program and would be off probation at the end of the year. On 5/13/15, ACS confirmed with Alabama child welfare services that the CH was in Alabama with the grandmother.

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

Issue:
Predetermination/Assessment of Current Safety and Risk

Summary:
The investigation reflected that there were two 7-day safety assessments completed on 4/27/15 and 5/13/15; the documentation did not reflect that ACS completed the required Investigation Determination safety assessment.

Legal Reference:
18 NYCRR 432.1(aa)
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 PS was not known to the SCR or ACS as a subject. The guardian was not known to the SCR or ACS as a subject more than three years prior to the fatality.

The SM was known to the SCR and ACS in two reports dated: 11/25/13 and 10/7/14. The allegation of the 11/25/13 report was IG of the SC and 6-yo-CH. On 1/30/14, ACS SUB the allegation. The allegation of the 10/7/04 report was IG of the 6-yo CH by the SM. On 11/20/14, ACS UNSUB the allegation of IG.

The SC and 6-yo CH were known as confirmed maltreated CHN in a report dated 1/20/13. The allegations were IG, SA, and IG. The report was IND.

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

Issue:	Adequacy of Progress Notes
Summary:	The Family Service Progress Notes reflected there were entries for visits that occurred on 7/13/15 and 9/9/15; however, there were no details of these visits.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP in the 7/18/16 FASP was inadequate as the Edwin Gould agency did not include the family's unstable or no housing condition.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Adequacy of Preventive Services casework contacts

Summary:	The Family Service Progress Notes reflected that between 6/15/16 and 10/27/16 the Edwin Gould did not have a successful home visit with the family although home visits were attempted.
Legal Reference:	18 NYCRR 423.4(c)(1)(ii)(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.

Preventive Services History

During the 11/25/13 investigation, ACS filed an Article Ten Abuse petition in Family Court naming the BF as the respondent. The SC and HS were paroled to the SM with court ordered supervision. ACS opened a service case on 12/20/13 and addressed concerns of DV in the presence of the SC and HS. The SM admitted she had a physical altercation with an adult at the shelter in which she resided. SM reported the BF assaulted her during the altercation with the other adult in the shelter.

The Initial FASP reflected the family received case management services for the SC and HS, and DV services for the SM. The family was referred to PPRS with Edwin Gould Preventive on 2/11/14 and signed for services on 2/24/14. The 7/18/16 FASP reflected that the SM completed Parenting Skills on 5/6/15 and DV counseling on 7/20/15. The SM was engaged in anger management counseling and was consistent with her attendance. The 12/20/16 FASP reflected that the three CHN were no longer in danger as they resided away from the BF and were safe in a family shelter. The Family Service Progress Notes reflected that between 6/15/16 and 10/27/16 the Edwin Gould agency did not complete a face-to-face home visit with the family although the agency made several attempts to visit the home. ACS maintained adequate contact with the family and closed the service case on 4/27/17.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: 12/19/2013	**To:** 02/21/2017
Explain: Full stay away OP's were in effect 12/19/13 to 2/21/17. All of the orders were issued in Family Court and covered all three CHN, and the SM. The OP's were all against the BF for the 3-yo CH and the SC.	

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