Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-18-050

Prepared by: New York City Regional Office

Issue Date: Nov 23, 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 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 05/24/2018
Initial Date OCFS Notified: 05/25/2018

Presenting Information

On 5/25/18, the SCR registered 3 reports concerning the death of the SC.

The 1st report alleged that on 5/24/18 the PS found the SC lying face up and unconscious on the bathroom floor and called 911. The report stated EMS found the SC with blood coming from his mouth and rectum. The report also stated there was a hammer lying next to the SC along with feces. The PS offered conflicting stories as to how he found the SC. The PS first stated the SC was wobbling when he walked and then passed out. He later stated he walked into the bathroom and found the SC passed out on the bathroom floor. The SC was taken to the hospital and pronounced dead at 11:07 P.M.

The 2nd report stated the SC had broken teeth, bloodied gums, bruising to the buttocks, and rectal tearing.
The 3rd report alleged the SC began to sustain injuries after the PS moved into the home. The report stated it was suspected the mother failed to intervene to protect the SC.

Executive Summary

The SC was 2 years old at the time of his death. The ME deemed the manner of death a homicide and provided details of the SC's multiple injuries. OCFS has not received the official autopsy report.

On 5/25/18, the SCR registered three reports concerning the death of the SC. The allegations of the reports were DOA/FATL, of the SC by the parent substitute (PS); and II, SDS, L/B/W, BS and IG of the SC by the mother and the PS.

The SC and his mother had recently moved out of the shelter system into a NYCHA apartment. ACS confirmed the mother had no other children, and had recently allowed the PS to reside in the home.

ACS initiated the investigation timely, but due to the case circumstances were unable to assess the home or interview the PS. The home was initially deemed a crime scene by the NYPD; and shortly after the initiation of the investigation, the mother obtained an attorney who advised her not to speak with ACS. There was no information to reflect the mother was charged concerning the incident.

On 5/25/18, ACS met with the mother who indicated that on 5/24/18, she left the SC with the PS while she worked from 2:00 P.M. to 11:00 P.M. The mother said after her shift, she realized she missed a 10:33 P.M. call from the PS. The mother said she called him back and he explained that he was assisting the SC brush his teeth when the SC "pooped himself" and began to "act weird". The PS told the mother that he asked the SC what was wrong, but the SC was acting "weird" so he began to administer CPR. ACS attempted to clarify the information the mother reported, but she was unable to do so as this was the information that was provided to her by the PS. The mother said the PS called 911 and the SC was transported to the hospital where he was pronounced dead.

The medical staff from Jacobi Hospital indicated the SC had multiple injuries that were suspicious in nature. However, the cause of death would be determined by the ME.

The NYPD stated the PS was arrested on 5/25/18, charged with Manslaughter in the 1st Degree and was held without bail at the Riker's Island Correctional Facility.

ACS' clearance of the PS revealed he had an indicated report involving his two children ages: 4 and 11 years old. ACS assessed the children to be safe in the care of their mother.

The SC's father had some contact with him and had no concerns about the level of care the mother provided for the SC. He did not know the PS.

On 8/10/18, ACS indicated the report, ACS substantiated the allegation of DOA/FATL against the PS; and II, SDS, L/B/W, and IG against the mother and the PS. The ME revealed the SC sustained severe injuries inflicted by the PS which included: the PS's shoe imprinted on the SC's body, hemorrhaging on the spinal cord and neck, extensive hemorrhaging in fat, muscle and skin (200 ML of blood); and a ruptured anus, which was caused by blunt force trauma to the SC's stomach or back. The SC had an abrasion to the face, missing teeth, torn rectum, internal bleeding and old and new marks all over his body. The ME also determined the SC was not being provided with adequate food; as he only had 3 ½ table spoons of food in his intestinal tract.

ACS unsubstantiated the allegation of BS by the mother and the PS as the ME's examination did not reveal any burns or scalding on the SC's body.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? Yes

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:
no surviving sibling.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/24/2018 **Time of Death:** 11:07 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 10:35 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Unknown if they were impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Other Adult - Parent Substitute	Alleged Perpetrator	Male	36 Year(s)

LDSS Response

On 5/25/18, ACS arrived at the precinct where the PS was being interrogated, but was not allowed to participate in the interview. The NYPD revealed the PS gave several accounts of events that did not coincide with the SC's injuries. Throughout the investigation ACS made efforts to obtain additional information from the NYPD and the Assistant District

Attorney concerning the PS's account of the events, but was unsuccessful due to the active criminal investigation. The PS was arrested and held without bail.

The medical staff from the ER indicated the SC arrived at the hospital with no heartbeat or pulse. The SC had bruises on his face and forehead, three missing teeth, marks on his belly, both sides of his upper thighs, and bruises on both his arms. The PS disclosed to the medical staff that at 10:15 P.M., the SC was in the bathroom trying to "potty" and he was in the bathroom with the SC. The PS reported the SC was holding his urine because he was "nervous". The PS said the SC "looked off" and took a step back then defecated on himself. The PS said the SC became unconscious and he began CPR; and then called 911. This account was not plausible.

ACS confirmed EMS were called at 10:35 P.M. and the PS performed CPR. The report stated EMS arrived at the home at 10:39 P.M. and transported the SC to the hospital at 10:52 P.M. where he was pronounced dead.

After learning the case address was deemed a crime scene, ACS met with the mother near a relative's home. The mother stated that on 5/24/18 she left for work sometime between 12:45 P.M. and 1:15 P.M. The mother said the SC was well when she left the home. The mother said when her shift ended she noticed she had a text from the PS stating he was on his way to the hospital with the SC. The mother also noticed she had a 10:33 P.M. missed call from the PS. The mother said she called the PS and asked why he was taking the SC to the hospital and he told her the SC was not breathing. The mother said she was confused and began to ask him what happened to the SC. The mother stated the PS told her the SC was brushing his teeth and did not "look like himself". The PS said the SC stopped breathing and he administered CPR and called 911. The mother said she had last spoken to the PS at 6:00 P.M. and he told her the SC was asleep. The mother said she had no concerns about the way the PS treated the SC as he was always calm. The mother said the PS was never aggressive towards her or the SC; and the SC gave no indication he was fearful of the PS. The mother admitted that both she and the PS smoked marijuana, but not in the SC's presence. When asked about the bruises on the SC's face, the mother stated on 5/18/18, the SC fell out of the stroller while in the care of the PS. The SC had sustained bruises on both sides of his face; and three of his teeth fell out. The PS explained the SC had fallen out of his stroller. The mother said she took the SC to the hospital where he was given an ice pack and prescribed ibuprofen. ACS verified this account with the hospital. There was no suspicion at the time of the injury; therefore, no report was registered with the SCR.

The mother said on the day of the incident it was "potty training day," she explained that every Thursday she would put a long shirt on the SC with no pamper to allow him to use his training seat. The mother said the PS was involved in the SC's training and was never upset about the SC wetting or defecating on himself.

The SC's pediatrician stated the SC was last seen on 1/17/17 for his well child visit and was healthy. The mother kept all the SC's appointments and he was always well groomed. The pediatrician noted the mother was never accompanied to the appointments by a male.

On 7/17/18, ACS contacted the ME who confirmed the SC's death was deemed a homicide and provided a detailed listing of the multiple blunt injuries the SC sustained that resulted in his death.

On 8/10/18, ACS indicated the report.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046461 - Deceased Child, Male, 2 Yrs	046462 - Mother, Female, 23 Year(s)	Burns / Scalding	Unsubstantiated
046461 - Deceased Child, Male, 2 Yrs	046463 - Other Adult - Parent Substitute, Male, 36 Year(s)	DOA / Fatality	Substantiated
046461 - Deceased Child, Male, 2 Yrs	046462 - Mother, Female, 23 Year(s)	Lacerations / Bruises / Welts	Substantiated
046461 - Deceased Child, Male, 2 Yrs	046462 - Mother, Female, 23 Year(s)	Internal Injuries	Substantiated
046461 - Deceased Child, Male, 2 Yrs	046463 - Other Adult - Parent Substitute, Male, 36 Year(s)	Swelling / Dislocations / Sprains	Substantiated
046461 - Deceased Child, Male, 2 Yrs	046463 - Other Adult - Parent Substitute, Male, 36 Year(s)	Lacerations / Bruises / Welts	Substantiated
046461 - Deceased Child, Male, 2 Yrs	046462 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
046461 - Deceased Child, Male, 2 Yrs	046463 - Other Adult - Parent Substitute, Male, 36 Year(s)	Inadequate Guardianship	Substantiated
046461 - Deceased Child, Male, 2 Yrs	046463 - Other Adult - Parent Substitute, Male, 36 Year(s)	Internal Injuries	Substantiated
046461 - Deceased Child, Male, 2 Yrs	046463 - Other Adult - Parent Substitute, Male, 36 Year(s)	Burns / Scalding	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐

Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
Only the mother was interviewed. The PS was taken into custody and subsequently held without bail.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?
☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Manslaughter **Degree:** 1			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
05/25/2018	Parent Substitute	Pending	Pending
Comments:	The PS was immediately arrested on 5/25/18 and charged with manslaughter. He was held without bail. Next court date was scheduled for 5/31/18.		

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐

Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
The SC had no surviving sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The mother had no other children. The PS was arrested and his children had no relationship with the SC.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/14/2017	Deceased Child, Male, 2 Years	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes

Report Summary:
The mother had recently relocated from the shelter to her own apartment.

The report alleged that the SC had a body odor and his clothing also smelled badly. The report stated the mother would often leave the SC in a soiled diaper. On 7/13/17, the SC was seen drinking from a dirty bottle that contained an excessive amount of mold. ACS confirmed the allegations of the report.

During the investigation, ACS observed a hookah pipe and 5 bottles of vodka in the home. The mother reported she did not smoke in the presence of the SC and the liquor was a house warming gift from friends. This information was not considered as it related to the mother's mood changes and poor care of the SC.

Report Determination: Unfounded | **Date of Determination:** 09/11/2017

Basis for Determination:
ACS unsubstantiated the allegation of IG by the mother; but cited the Children's Aid Society (CAS) provided pictures of the dirty bottle with the mold. ACS also cited and the DC account which noted the mother would bring the SC to the DC in a soiled diaper on a daily basis. ACS inappropriately unsubstantiated the allegation based on some improvements the mother made during the investigation and not the circumstances that caused for the report to be made.

OCFS Review Results:
ACS did not conduct a thorough investigation. Although ACS made relevant collateral contacts, ACS did not consider information of mandated reporters from the CAS and the SC's DC provider when making a determination. These two collaterals had had recent contact with the SC and witnessed the SC's condition as noted in the report. During the investigation, it was mentioned the mother had a "husband", but this was not explored further with relevant collaterals. ACS did not consider the mother's history which consisted of an indicated report for similar allegation and the PPRS to address these concerns. The PPRS had been recently closed.

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
The comments entered to support the safety factors did not specify how they impacted on the care the mother provided to the SC. Also, the parent/caretaker actions were not properly documented.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

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

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
ACS did not conduct a thorough investigation of this report. ACS did not utilize the information gathered to properly assess risk and safety. Also, there was no supervisory guidance relevant to the case circumstances. This was evident by the approval of the determination, as ACS had credible evidence to indicate the report against the mother; however, the report was unfounded.

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

Action:

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
ACS did not respond to the questions in the RAP according to the information documented in the investigation or the family's history. Also, some of the questions were not explored and/or fully addressed during the investigation. In addition, the father was not added as a secondary caretaker; he continued to have some involvement with the SC.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Appropriateness of allegation determination
Summary:
ACS did not consider relevant information provided by mandated collateral contacts to properly determine this report. ACS unfounded the report in spite of having credible evidence to substantiate the allegation of IG.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/15/2016	Deceased Child, Male, 10 Months	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Deceased Child, Male, 10 Months	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The report alleged the mother was residing in unsanitary conditions with the SC who was 10 months old. It was alleged there was garbage strewn around the home, which included soiled diapers, dishes piled in the sink, and old garbage bags in areas where the SC crawled and ate. As a result, the home was emitting a strong foul odor. The report further stated the SC was left in soiled diapers for long periods of time.
The family resided in a shelter. ACS, made visits to the home and observed the condition described to the SCR report.

Report Determination: Indicated | **Date of Determination:** 08/12/2016

Basis for Determination:
The allegations of IG and IF/C/S based on ACS' observation of the mother's home which were unsanitary. ACS cited that even though the matter was addressed with the mother, she made no effort to correct the problem.

OCFS Review Results:
This was not a thorough investigation as there were insufficient collateral contacts. When collaterals were made, relevant

questions concerning information about the mother's ability to care for the SC were not asked. The conditions of the home, the mother's lack of motivation to address this concern or understand the safety and risk issues this presented for the SC were not properly assessed. ACS indicated the report and noted there were safety factors that presented immediate danger of serious harm but did not conduct a child safety conference or develop a safety plan.

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

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
ACS completed the RAP without inadequately interviewing the father concerning issues listed. Therefore, the questions concerning the father were answered without a proper assessment. ACS did not make diligent efforts to discuss the safety concerns relevant to the report.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
There was supervisory notes throughout the investigation; however, there was no follow up to review the report prior to the determination. The allegation of the report were confirmed, but not properly assessed. This case required a CSC based on the SC's age, conditions of the home, mother's failure to keep curfew and inability to follow up on the in-house meeting to work towards permanent housing.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
ACS' selected a safety decision noting there were safety factors that presented immediately danger of serious harm, but no CSC was held and there was no safety plan completed. Comments for the safety factors consisted of the conditions of the home, but did not specify or describe the impact the mother's inability for the SC.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
ACS selected appropriate safety factors, but the comments to support safety factors consisted of the conditions of the home. The was no assessment to specify or describe the impact the mother's inability to care for the SC.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS made contact with the father, PGGM and the source, but did not focus the interview on assessing the mother's level of maturity or interaction with the SC. There was no interview with the pediatrician not the daycare.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

The mother had no history for this time period.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Preventive Services History

The family was referred by ACS for PPRS; and the mother accepted services on 9/6/16. The concern at the time of the referral was due to the mother's home management skills and the need to develop parenting skills. The mother was residing in a shelter where the conditions of her room presented serious risk factors for the safety of the SC. The CP worked individually with the mother to help her develop home management and budgeting skills as well as parenting skills. The case remained open until 5/25/17. The mother made some improvements in her ability to keep the home clean and care for the SC. However, the mother began to work and was not making herself available for appointments. The SC was healthy and received day care services. The PPRS last contact with the family was 5/5/17.

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