Child Fatality Report

Report Identification Number: NY-19-009

Prepared by: New York City Regional Office

Issue Date: Jan 17, 2020

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: 8 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 03/23/2018
Initial Date OCFS Notified: 01/22/2019

Presenting Information

On 1/22/19, the SCR registered a report that alleged the SC required emergency medical treatment after the mother found him unresponsive in the home wrapped in multiple layers of queen size sheets and blankets. The report alleged the father was present in the home at the time of the incident. The report stated the mother called 911 and the SC was transported via ambulance to a hospital. Later on the same day, he was transferred to another hospital for a higher level of care. The SC was pronounced dead on 3/23/18 by hospital medical staff. The SC had no known pre-existing medical conditions. An autopsy was conducted on 3/24/18 and the report was completed on 1/22/19. The report determined the manner of death was deemed a homicide. The roles of the siblings were unknown.

Executive Summary

This fatality was originally reported to the SCR on 3/23/18 and a report was prepared and issued by NYCRO on 9/25/18. The SC was 8 months old when he died on 3/23/18. The allegations of the 1/22/19 re-report were DOA/Fatality and Inadequate Guardianship of the SC by the parents.

According to the information obtained from the NYPD, the father told the police that he was smoking marijuana and caring for the children while the mother went to an appointment. The father also disclosed he wrapped the SC in a comforter, covering the SC's nose and mouth, placed him face down in the crib and then walked away. The father said this was the first time he had ever wrapped the SC in this manner; but did not provide an explanation as to why he did this on the day of the incident. The father denied the SC was crying or "fussy". The ME recently determined the manner of death to be a homicide. The father had been arrested and charged with Assault and Manslaughter in the 1st Degree. Law enforcement indicated the charges against him would be upgraded in light of the new information from the ME.

On 1/22/19, the SCR registered a subsequent report regarding the death of this male child. The report provided details regarding the death of the child and stated it was determined that the cause of death was hypoxi-ischemic encephalopathy due to smothering. Both parents were named as subjects of the report.

ACS initiated the report within the required time frame and appropriately contacted the ME for information. The ME confirmed the cause and manner of death. Since there was an already open case stemming from the original report, ACS made the court aware of the new information. Throughout the new investigation, ACS conducted assessments of the surviving children and it was determined the children were physically safe in foster care. Currently, the surviving children are in the care of the MGU and foster care is monitoring the family. The mother is in receipt of services.

On 6/3/19, ACS substantiated the allegations of DOA/Fatality, and Inadequate Guardianship of the SC against the father based on his actions wherein he wrapped the SC in two comforters, covering the child's head, and placed the child face down in the crib. The child suffocated. To support the decision, ACS cited the ME's report which stated the cause of death was complications of hypoxic-ischemic encephalopathy due to smothering and the manner of death was homicide.

ACS substantiated the allegation of Inadequate Guardianship of the SC against the mother on the basis that the mother knew there was a full stay-away order of protection against the father for the family, but allowed the father to be with the children unsupervised. During the unsupervised time the child was injured and subsequently died.

ACS unsubstantiated the allegation of DOA/Fatality against the mother; however, the basis for the determination was not adequately explained at the conclusion of the investigation.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

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? No

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/23/2018 **Time of Death:** 11:16 AM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: New York
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
At time of incident supervisor was:

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	8 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	21 Year(s)

LDSS Response

ACS investigated the 1/22/19 report and re-interviewed medical staff at the ER, NYPD, ME, and family members. ACS also made a visit to the foster home where the surviving siblings were placed, and determined the children were physically safe in the home.

ACS attempted to re-interview the mother; however, she was not inclined to be interviewed. ACS held interviews with relatives who reported they had no knowledge of physical altercations between the parents.

The ADA indicated that during the interrogation with the NYPD, the father disclosed he wrapped the SC in a comforter, covering the SC's nose and mouth, placed him face down in the crib and then he walked away. The father said this was the first time he had ever wrapped the SC in this manner; but did not provide an explanation as to why he did this on the day of the incident. The father denied the SC was crying or "fussy". The NYPD crime scene unit observed there were two

queen size comforters in the crib that were used to wrap the SC, a sheet and two blankets. The father informed the NYPD that he was smoking marijuana all day while he cared for the children. The NYPD found marijuana in the apartment. The NYPD and ADA indicated charges would be upgraded against the father who remains in prison. The father was not re-interviewed.

ACS indicated the children had been visiting the father through the Children of Incarcerated Parents (CHIPS) program; however, a reassessment of the visits would be completed, in light of the manner of death of the SC.

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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: There was no documentation of an MDT investigation; however, 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
050549 - Deceased Child, Male, 8 Month(s)	050535 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
050549 - Deceased Child, Male, 8 Month(s)	049484 - Father, Male, 21 Year(s)	DOA / Fatality	Substantiated
050549 - Deceased Child, Male, 8 Month(s)	050535 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
050549 - Deceased Child, Male, 8 Month(s)	049484 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:

The siblings were too young to be interviewed at the time of the SC's death.

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 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	☒	☐	☐	☐
Explain: N/A				

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: The siblings remain in foster care.				

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: Assault **Degree:** 1			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
03/23/2018	Father	Pending	Pending
Comments:	Father was arrested and held without bail at the Riker's Island Correctional Facility. The pending charges were Assault and Manslaughter in the 1st Degree.		

	According to ACS, the charges against the father would be upgraded in light of the determination made by the ME that the child's death was a homicide.

Criminal Charge: Manslaughter **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Father	Pending	Pending
Comments:	Father was arrested and held without bail at the Riker's Island Correctional Facility. The pending charges were Assault and Manslaughter in the 1st Degree. As of 5/19/19, ACS documented the father's charged with Manslaughter in the 2nd degree. According to ACS, the charges against the father would be upgraded in light of the determination made by the ME that the child's death was a homicide		

Have any Orders of Protection been issued? No

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Supervised vists

Additional information, if necessary:
The father is currently recieving supervised visits while incarcerated.

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:
As a result of the fatality, in March, the siblings were immediately removed and placed in foster care for safety reasons. The children remain in foster care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
As a result of the fatality, in March, the father was immediately arrested and the children were placed in foster care where they currently remain.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

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

03/23/2018	Sibling, Male, 4 Years	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 4 Years	Mother, Female, 20 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 2 Years	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Years	Mother, Female, 20 Years	Lack of Supervision	Substantiated	
	Deceased Child, Male, 8 Months	Father, Male, 20 Years	DOA / Fatality	Substantiated	
	Deceased Child, Male, 8 Months	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 8 Months	Father, Male, 20 Years	Internal Injuries	Substantiated	
	Deceased Child, Male, 8 Months	Father, Male, 20 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Male, 8 Months	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 8 Months	Mother, Female, 20 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 4 Years	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Years	Father, Male, 20 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 2 Years	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Years	Father, Male, 20 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
On 3/23/18, the SCR registered a report stating the SC was admitted to the hospital on 3/22/18 in critical condition and was put on life support in the pediatric ICU due to unexplained injuries. The report alleged the SC was solely in the care of the father for approximately 2 hours when he sustained the injuries. The report further stated the SC was brain dead and on 3/23/18, he was taken off the ventilator and pronounced dead. The report stated the father was arrested as it was suspected that he played a role in the SC's death.

ACS filed an Article 10 Petition at the Manhattan Family Court and the surviving siblings were placed in the care and custody of the Commission of ACS.

Report Determination: Indicated | **Date of Determination:** 06/03/2019

Basis for Determination:
ACS substantiated the allegations of DOA/FATL and II of the SC by the father based on the fact that he was arrested for inflicting the II on the SC which caused his death. ACS substantiated the allegations of PD/AM because he disclosed he had been smoking marijuana while caring for the children.

The allegations of IG by the parents and LS by the mother for the children were substantiated because the mother left the children in the care of the father which was a violation of the OOP.

OCFS Review Results:
ACS appropriately indicated the report and substantiated the allegations against the father for the three children. However, ACS' determination was not timely and the allegation narratives were not concise. The documentation reflected ongoing supervisory oversight, but there was no guidance in completing the instrument for the safety assessments.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The assessment was completed timely, but the instrument for the safety was not completed timely. Safety factors were either not relevant or not supported by the comments.
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:
Timely/Adequate 24 Hour Assessment
Summary:
The assessment was completed timely, but the instrument for the safety was not completed timely. Safety factors were either not relevant or not supported by the comments.
Legal Reference:
SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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/Supervisor Review
Summary:
There was inadequate supervisory oversight which was evident throughout the investigation; documentation of progress notes was not concise, safety assessments were approved although not properly completed, approval for the determination was significantly overdue even though there was credible evidence to do so timely.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
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 30-Day Safety Assessment
Summary:
The assessment was completed timely, but the instrument for the safety was not completed timely. Safety factors were either not relevant or not supported by the comments.
Legal Reference:
CPS Program Manual, Chapter 6, K-2
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)
03/22/2018	Sibling, Male, 4 Years	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 4 Years	Father, Male, 20 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Male, 4 Years	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Years	Mother, Female, 20 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 2 Years	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Years	Mother, Female, 20 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 2 Years	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Years	Father, Male, 20 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Male, 8 Months	Father, Male, 20 Years	Inappropriate Custodial Conduct	Substantiated	
	Deceased Child, Male, 8 Months	Father, Male, 20 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Male, 8 Months	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 8 Months	Mother, Female, 20 Years	Lack of Supervision	Substantiated	

Report Summary:
On 3/22/18, an initial report was registered with the SCR noting the SC was found by the mother face down in his crib, and wrapped in blankets. The SC was unconcious and had “a purple complexion.”

According to the report, the mother left the three children in the care of the father for about two hours. The report noted the SC was awake and well when the mother left the home. When the mother returned, the father was laying on the bed with the two siblings. The mother contacted 911, and EMS transported the SC to NY Downtown Presbyterian Hospital.

Report Determination: Indicated | **Date of Determination:** 06/03/2019

Basis for Determination:
ACS substantiated the allegations of PD/AM by the father; and LS and IG of the three children by the parents. ACS cited the parents arranged for the father who was under the influence of Marijuana/Hashish to care for the children unsupervised while the mother ran an errand knowing this was a violation of an active OOP. While unsupervised, the father smothered the SC and he died as the result of complications of hypoxic-ischemic encephalopathy. The ME ruled his death a homicide.

OCFS Review Results:
The investigation revealed the parents were in violation of the OOP as the mother left the children in the care of the father when he became unresponsive. The SC was admitted to the hospital and subsequently died. The father admitted to the NYPD that he hurt the SC and was arrested on 3/22/18. He was charged with Assault 1st Degree and remains at Riker's Island; pending additional criminal charges. ACS has not attempted to interview the father.

On 3/22/18, the siblings were removed from the mother's care. ACS filed an Article 10 Abuse Petition and they were remanded and placed in a kinship home.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/19/2017	Deceased Child, Male, 10 Days	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The report stated the mother gave birth to the SC on 7/9/17. The report alleged the mother had two children in foster care due to abuse or neglect. The SC was born premature and was in the NICU. The report also alleged the mother had not visited the SC, since she was discharged from the hospital. The report stated the the SC was ready for discharge, but the mother could not be contacted.

The investigation revealed the siblings were not in foster care.

Report Determination: Unfounded | **Date of Determination:** 07/28/2017

Basis for Determination:
ACS unsubstantiated the allegation of IG of the 10 day old SC as ACS determined the mother had provisions for the SC. The investigation revealed that the hospital staff did not have updated information of the mother's contact number and were unable to reach her.

OCFS Review Results:
The investigation was not thorough and did not properly assess the risk and safety factors in this case. There were active OOPs from Criminal and Family Courts against the father with the mother and the siblings as the protected parties. ACS was informed by the hospital staff that the father was present at the delivery of the SC and was visiting the hospital. ACS did not consider this a violation of the OOP. ACS suspected the father may have been residing in the home, but they did not explore the matter. There were supervisory directives that were not completed. ACS completed this investigation prematurely based on the fact that the family was under COS, but that decision was inappropriate.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The father was not listed as a secondary caretaker in the RAP. ACS did not reflect that responses to the questions in the RAP were addressed in the progress notes.

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:
The allegation determination was not fully investigated and focused solely on the SCR narrative. ACS obtained information that confirmed the father violated the OOP, and the mother failed to protect the children, but did not explore this safety concern further. This information provided some credible evidence to substantiate the allegation of all three children by the parents.

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.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
ACS did not properly support the selected safety factors selected.
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 no collateral contacts with the father, relatives, pediatrician, mother clinician, or relevant entities for the father's criminal case.
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.

Issue:
Appropriateness of allegation determination
Summary:
The allegation determination was not fully investigated and focused solely on the SCR narrative. ACS obtained information that confirmed the father violated the OOP, and the mother failed to protect the children, but did not explore this safety concern further. This information provided some credible evidence to substantiate the allegation of all three children by the parents.
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.

Issue:
Failure to provide notice of report
Summary:
The NOE was not issued for 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:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
ACS did not properly support the selected safety factors. The overall documentation of the safety assessment was not clear.

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:
Review of CPS History

Summary:
ACS did not consider the family's history when making a determination, completing assessment to conduct a thorough investigation of the report.

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

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 Investigations

Summary:
ACS did not conduct a thorough investigation and seemingly ignored crucial information regarding the father's violation of the OOP and the mother's failure to protect the children in that regard. The presence of the open COS case should not have substituted for a thorough investigation pursuant to Social Services Law.

Legal Reference:
SSL 424.6 and 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/28/2017	Sibling, Male, 3 Years	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 9 Months	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 3 Years	Father, Male, 19 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 9 Months	Father, Male, 19 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The report alleged the father had a history of physically assaulting the mother. The report stated that on 5/28/17 the father struck the mother on the head in the presence of the siblings. The report alleged the mother sustained redness and swelling. The report noted the father was arrested and charged with assault 3, reckless assault and aggravated harassment in the 2 second degree. The report also stated the father had a prior assault incident in July that did not result in criminal action.

Report Determination: Indicated | **Date of Determination:** 06/02/2017

Basis for Determination:
ACS substantiated the allegation of IG of the children by the parents. ACS cited the father's actions of assaulting the mother in the presence of the siblings and his arrest. However, ACS did not provide a narrative to support the allegation determination against the mother.

OCFS Review Results:
The investigation was not thorough. The documentation noted there was another open report, but these were not consolidated. There was no effort to contact the father. The mother was pregnant and there was an active OOP due to expire on 11/28/17. There were no collaterals made to follow up on the mother's pregnancy or how the father accessed the home. A Child Safety Conference (CSC) was scheduled for 6/2/18, but the CSC was not documented in this investigative stage. The 7-day safety assessment reflected there were safety factors that placed the children in immediate danger of serious harm. There was no safety plan documented; and the comments did not support the selected safety factors.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
ACS selected a safety decision that reflected there were safety factors that placed the children in immediate danger, but did not document a safety plan. The comments documented did not properly support the selected safety factors.
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:
Failure to Provide Notice of Indication
Summary:
The CONNECTIONS event list did not reflect that the Notices of Indication were issued to 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:
Failure to provide notice of report
Summary:
The CONNECTIONS event list did not reflect the Notices of Existence were issued o the parents.
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:

Contact/Information From Reporting/Collateral Source

Summary:

There were no relevant collateral contacts such as: the children's pediatrician, mother's OBGYN, NYPD or family members.

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.

Issue:

Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:

There was no effort to contact the father who was also listed as a subject in this report.

Legal Reference:

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

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)
05/01/2017	Sibling, Male, 3 Years	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 16 Months	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Father, Male, 19 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 16 Months	Father, Male, 19 Years	Inadequate Guardianship	Substantiated	

Report Summary:

On 4/27/17, ACS received additional information from the SCR alleging the mother arrived late to the mother/child program and left the children with the staff.

An SCR report followed on 5/1/17 alleging the mother had a history of untreated mental health issues. The report alleged that as a result she received assistance with her children through her residential care. The report alleged the mother had been AWOL from the residence since 4/26/17. Due to the mother's mental heath, there were concerns the children were at high risk of harm in her care.

During this investigation, the mother was pregnant with the SC and was in the process of a trial discharge.

Report Determination: Indicated | **Date of Determination:** 06/21/2017

Basis for Determination:
ACS substantiated the allegation of IG of the siblings by the father and unsubstantiated the allegation of IG of the siblings by the mother. ACS based their decision on the fact that the father physically assaulted the mother in the presence of the siblings. The father was charged with Assault in the 3rd Degree, and OOPs were issued by Criminal and Family courts on behalf on the mother and siblings.

ACS had credible evidence to substantiate the IG against the mother as she continuously went AWOL with the children and later denied the father's physical assault. The CP and ACS suspected the mother was allowing the father in the home as she denied them access to the home on several occasions

OCFS Review Results:
ACS did not conduct a thorough investigation. Collateral contacts did not focus on gathering information to assess the parents' ability to care for the children. The documentation was not clear and concise. The mother was not cooperative; therefore, ACS filed an order to show cause to produce the children.

On 6/5/17, ACS filed an Article 10 Neglect Petition due to the father physically assaulting the mother while the children were in the home. The father was named as a respondent, and the children were released to the mother with COS. A stay away OOP was issued against the father. The father had been arrested on 5/28/17.

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

Issue:
Adequacy of Progress Notes
Summary:
The documentation in this case was not clear and concise. The details of significant events were not provided. In addition, there was no description of the home during the visits.
Legal Reference:
18 NYCRR 428.5
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.
PIP Requirement:
N/A

Issue:
Appropriateness of allegation determination
Summary:
The mother's actions revealed she used poor judgment concerning the care of the children. The mother was going AWOL and not notifying anyone of the children's whereabouts. Later, it was revealed there were DV issues with the father who she allowed in the home.
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.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:

There were many supervisory directives that were not completed. The investigation lacked detail and there were insufficient efforts to include descriptions of the home, gather relevant information of the risk and safety factors concerning the parents' actions and lack thereof.

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:

Failure to Provide Notice of Indication

Summary:

CONNECTIONS database does not reflect that a NOI was issued 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:

Failure to provide notice of report

Summary:

CONNECTIONS database did not reflect that the NOE was issued for 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:

Timely/Adequate Seven Day Assessment

Summary:

The safety assessment did not note concerns about the mother's violent behavior and untreated mental health issues.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/11/2017	Sibling, Male, 5 Months	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 3 Years	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The report stated the mother was in a mother/child program with her two children. The report alleged the mother left the program at 9:37 A.M. on 2/10/17 to pick up a computer in Manhattan and left her children with staff. The mother had not returned to the program or been in contact with staff. It was alleged, the mother failed to make adequate plans for the care of her children for a long period of time. The mother's whereabouts were unknown. The mother had left the children at the mother/child program without a plan for their care on several other occasions.

Report Determination: Unfounded | **Date of Determination:** 04/12/2017

Basis for Determination:
ACS unsubstantiated the allegation of IG of the children by the mother due to "lack of credible evidence". ACS cited the mother was providing the children with their basic needs and the children were seen without marks or bruises during the visits. However, the mother did not plan with the program for extended care of the children. On the day of the reported incident, the mother arrived at the program at approximately 2:00 A.M. and did not provide a viable explanation for her absence. In addition, that was not the first time the mother behaved in the manner described. ACS had some credible evidence to substantiate the allegation of IG.

OCFS Review Results:
This was not a thorough investigation. ACS did not use the information gathered to properly assess the risk and safety of the children. The father was not listed as a secondary caretaker in the RAP, and once again the issue of the reported DV was not addressed with either parent. ACS based their determination on the mother's improvement after ACS' involvement and not what led to the making of the report. The mother was not held fully accountable for her poor judgment concerning the care of the children. ACS recommended that the foster care agency monitor the mother's care of the children closely.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
ACS did not list the father in the RAP as a secondary caretaker. ACS did not respond accurately to the questions in the RAP or explore information thoroughly.
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:
The CONNECTIONS event list did not reflect that a NOE was issued 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:
Timely/Adequate Seven Day Assessment
Summary:

ACS selected a safety decision that noted there were safety factors present that placed the children in danger of serious harm. However, the comments for the selected safety factors did not support the safety decision.

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:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

ACS noted there were no safety factors present; however, the mother had poor judgment that could be related to her untreated mental health issues and/or drug use.

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:

Appropriateness of allegation determination

Summary:

ACS had some credible evidence to substantiate the allegation of IG as the mother did not make proper arrangements for the care of the siblings and did not provide a viable explanation for staying out of the program overnight. The mother exercised poor judgment; and ACS did not explore whether she stayed out with the father who had recently been physically violent against her.

Legal Reference:

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/02/2016	Sibling, Male, 2 Years	Mother, Male, 18 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 10 Months	Mother, Male, 18 Years	Inadequate Guardianship	Substantiated	

Report Summary:

The report alleged the mother had the siblings in her care when she threatened to throw herself on the train tracks, if the father did not stay out late with her. The mother had no formula for the children and it was alleged she might have begun to smoke marijuana again.

ACS spoke to the PGM of the mother's 2nd child who indicated the mother followed the father home on 11/1/16 at 10:00 P.M. and she (PGM) sent her to the mother/child program at 7:00 A.M on 11/2/16.

Report Determination: Indicated | **Date of Determination:** 12/23/2016

Basis for Determination:
ACS substantiated the allegation of IG of the siblings by the mother. ACS based their determination on the mother's interview where she admitted to making a statement to the SC's father, indicating she would throw herself on the train tracks; if he didn't stay out with her. ACS cited the mother admitted to smoking marijuana and refused to submit to drug screening. ACS also cited the mother had mental health issues that she refused to address through clinical services.

OCFS Review Results:
ACS did not conduct a thorough investigation as collateral contacts were not used to address all safety concerns involving mental health, domestic violence and drug use. ACS spoke to the father and confirmed the mother's threat to hurt herself on 11/1/16, but he was not included when assessing the safety and risk. The mother and the siblings often visited his home, but no home visit was made for an assessment. Based on the mother's history, she had failed to follow up with MH services, but this issue was not properly addressed even though it was relevant to the information in the SCR report. The investigation revealed that on 7/7/16, the father punched the mother on her ribs and thigh.

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

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
The directives in this case were not case specific for risk and safety concerns and failed to properly explore critical issues as the mother's history of mental illness, drug use, DV and the lack of compliance by the mother. There was no efforts to fully include the father in this investigation or explore his role as a possible subject due to the assault on the mother.
Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

ACS was aware that the father of the mother's 2nd child was involved in the child's life, but did not include him as a secondary caretaker in the RAP. The mother reported that she would spend the weekend at the father's home, but there was no documentation of his role as it pertained to the children.

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:

Timely/Adequate Seven Day Assessment

Summary:

The selected safety decision for the 7-Day safety assessment reflected there were safety factors that placed the children in immediate and impending danger of serious harm. However, the selected safety factors were not properly supported by the documented comments.

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 some relevant collateral contacts, but did not focus on issues disclosed during the investigations such as a recent DV incident involving a physical altercation with the father. ACS did not coordinate with the CP contact with the therapist the mother was alleged to be seeing in the previous investigation.

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.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

ACS documented there were no safety factors; however, many safety concerns were not properly explored. The mother had known mental health diagnosis, but had not enrolled in services the previous investigation. A domestic violence incident of a physical altercation with the father was previously disclosed, but was not explored to assess the current circumstances.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/18/2016	Sibling, Male, 1 Years	Mother, Female, 17 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 1 Years	Mother, Female, 17 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The report alleged that on 4/17/16, the mother tried to sneak out of home with the one-year-old sibling and as a result the sibling fell down the stairs and hurt his head. The sibling sustained a large lump on his forehead.

The report alleged the mother did not have the sibling medically examined. The mother resided in a mother/child program and was pregnant with her second child.

Report Determination: Unfounded | **Date of Determination:** 06/17/2016

Basis for Determination:
ACS unsubstantiated the allegations of L/B/W and IG of the 17-month-old sibling by the mother. ACS cited that although the mother left the facility late with the sibling when he had an accidental fall, she waited for the nurse to assess the sibling and took him to the hospital. However, according to the program staff they directed the mother to take the sibling to the doctor and she refused. The mother took the sibling to the hospital only after ECS went out to the home.

ACS based their determination on the mother's "improved" behavior after ACS's involvement and not the reason that cause for the making of the report.

OCFS Review Results:
ACS did not conduct a thorough investigation and did not use relevant information gathered from the mother/child program who had daily contact with the mother and provided care for the sibling. The program staff had concerns about the mother taking the sibling out of the home at 3:00 A.M. and returning with a smell of marijuana, had outbursts and fits of anger at the program, and was involved in sexual videos where the sibling was allegedly present. ACS did not thoroughly explore or properly address these issues. ACS focused on the mother's personal achievements, but did not address how her aggressive behavior impacted negatively on her ability to care for the children.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The safety decision selected noted there were safety factors that placed the sibling in immediate danger of serious harm. The comments to support the selected safety factors did not specify how they impacted on the mother's ability to care for the sibling. No safety plan was documented.

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

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:

ACS did not include the father of the children when completing the Risk Assessment Profile. In addition, responses for questions in the RAP were not explored.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The determination safety assessment listed there were no safety factors; however, concerns about the mother's drug use, judgment and behavior were not fully addressed and/or explored.

Legal Reference:

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

Action:

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

Issue:

Appropriateness of allegation determination

Summary:

ACS unsubstantiated the allegations of the report based on the mother's actions after the report was registered and not based on the circumstances that led to the report. ACS had 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 fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Failure to provide notice of report

Summary:

The CONNECTIONS database did not reflect that ACS issued a NOE to the father. ACS did not make diligent efforts to persuade the mother to reveal the name of the father through the foster care records or the assistance of the MGU.

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.

Issue:

Adequacy of Progress Notes

Summary:

Several progress notes were not contemporaneous and/or precise. In addition, some did not reflect continuity of the information received.

Legal Reference:
18 NYCRR 428.5
Action:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

There is no relevant CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

The family has no known CPS history outside NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 07/27/2017

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 07/27/2017

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? FASP was due 1/5/18, but it was completed 1/25/18.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☐	☒	☐	☐
Was the FASP consistent with the case circumstances?	☐	☐	☐	☒

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: The family was under COS and ACS referred the family to the Lower Eastside PPRS.				

Required Action(s)

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The information in the RAP was not consistent with the case circumstances. The documentation of the progress notes did not reflect that many of the questions in the RAP were discussed/explored.
Legal Reference:	18 NYCRR 432.2(d)

Action:	LESFU must meet with the staff involved in this fatality 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 Preventive Services casework contacts
Summary:	The contact with the family did not reflect there were discussions concerning the safety and risk factors presented at the time of the referral.
Legal Reference:	18 NYCRR 423.4(c)(1)(ii)(d)
Action:	LESFU must meet with the staff involved in this fatality 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 Progress Notes
Summary:	The progress notes of the CP and supervisor consisted of repetitive information that did not focus on the assessment of safety or risk of the children. There was very little to no relevant guidance by the supervisor.
Legal Reference:	18 NYCRR 428.5
Action:	LESFU must meet with the staff involved in this fatality 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 case recording in FASP
Summary:	The FASP was not completed timely and lacked adequate assessments. Much of the information documented was not evident in the progress notes.
Legal Reference:	18 NYCRR 428.6(a)
Action:	LESFU must meet with the staff involved in this fatality 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.

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/05/2017	There was not a fact finding	There was not a disposition
Respondent:	047321 Father Male 21 Year(s)	
Comments:		

Have any Orders of Protection been issued? Yes	
From: 12/15/2017	**To:** 04/30/2018
Explain: A temporary OOP was issued against the father on behalf of the mother and the children. A stay away OOP remains active against the father on behalf of the children. The OOP stipulated the father is allowed to see the children while incarcerated with the supervision of the MGU and ACS.	

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