Child Fatality Report

Report Identification Number: NY-19-081

Prepared by: New York City Regional Office

Issue Date: Dec 27, 2019

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 8 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 07/05/2019
Initial Date OCFS Notified: 07/05/2019

Presenting Information

On 7/5/19, the SCR registered a report alleging that at approximately 10:00 A.M, the 10 yo sibling found the 8 yo SC, dead in her bed face down. EMS was called; the paramedics arrived on the scene at 10:34 A.M. and found the mother outside of the home with the SC. EMS determined the SC had been dead for at least three hours as rigor mortis was fully set. The SC was gray in color and had dried blood caked under her nose, but there was no visible injury. The report stated the SC had no preexisting medical condition.

Executive Summary

The SC was 8-years old when she died on 7/5/19. The autopsy report listed the cause of death as undetermined and the manner of death natural.

On 7/6/19, the SCR registered a report with allegations of DOA/FATL and IG of the SC by the parents. The SC resided with her parents and 10 yo sibling. At the time of the incident, the father had left the home to go to work.

According to ACS' investigation, the SC was found unresponsive by her sibling who alerted the mother and she in turn called 911 and the father. The SC was transported to the hospital where efforts to resuscitate the SC failed and she was pronounced dead.

ACS initiated a timely investigation and assessed the sibling to be safe in the care of his parents. In addition, the home was assessed to have no safety concerns and adequate provisions were observed for both children. The sibling was medically cleared and interviewed at the CAC. ACS continued to make visits to the home throughout the investigation, and the sibling was observed to have no marks or bruises.

ACS interviewed first responders and the ME and no one had concerns about the circumstances surrounding the SC's death. None of the responders observed any marks or bruises on the SC's body.

As per protocol, ACS held Child Safety Conferences (CSC) and it was determined there was no need for court intervention.

Prior to the conclusion of the investigation, the family relocated to a new apartment which ACS assessed as not having any safety concerns. The family was offered PPRS, bereavement services and assistance with funds for the SC's burial, but they declined.

On 10/24/19, ACS unsubstantiated the allegations of DOA/FATL and IG of the SC by the parents. ACS cited the cause and manner of death listed on the autopsy report and the fact that the SC had all her basic needs met by the parents.

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? 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:
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: 07/05/2019 **Time of Death:** 11:00 AM

Time of fatal incident, if different than time of death: 11:17 AM

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

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] Other

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	8 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	42 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)

LDSS Response

ACS initiated the investigation by interviewing the first responders and family members.

The NYPD stated there was no suspicion of abuse or criminality surrounding the circumstances of the SC's death. The detective said the attending physician and first responders did not observe any signs of trauma to the SC's body.

ACS contacted EMS from NYU Medical Center who stated that at approximately 10:34 A.M. a call was received, and paramedics arrived at the case address at approximately 10:41 A.M. EMS stated the mother was out in the street wailing and very emotional, and the SC was lying on a stretcher as another EMS team was at the scene. Resuscitation efforts were made, but the SC had no signs of life and rigor mortis had already set. EMS called ahead to Maimonides Medical Center (MMC) and arrived at the ER at approximately 10:55 A.M. The medical staff continued resuscitation efforts to no avail. The SC was pronounced dead at 11:17 A.M.

ACS interviewed the family and the sibling was seen at the CAC. According to the sibling, he and his family went to visit his parents' friends on 7/4/19 and spent the day at their home. The sibling reported he and the SC played with the friends' children and returned to their home at around 10:00 P.M. The sibling said he and the SC went to lay on their beds and he fell asleep around 11:30 P.M., at that time, the SC was watching television. The sibling said he slept throughout the night and on 7/5/19, he awoke sometime between 9:00 A.M. and 10:00 A.M. The sibling said his mother asked him to wake the SC, but when he tried to do so the SC did not respond. The sibling stated he alerted the mother who went to the room and turned over the SC. The sibling said he observed blood coming out of the SC's mouth. The sibling said the mother took the SC from the bed, went outside the apartment, and asked the neighbors to call 911 for assistance. When asked about the family's interaction, the sibling reported the parents did not use corporal punishment to discipline him or the SC and he denied there was domestic violence in the home. The sibling had no marks or bruises during the interview.

The father stated that on 7/5/19, he woke up at 5:00 A.M. and the SC was alive. The father said the SC was lying in bed awake and had spoken to him before he left the home. The father said he left the home at about 8:00 A.M. to go to work, and did not go back to speak to the SC. The mother said she allowed the SC to sleep late because school was out and they

planned to leave the home to go to the park at about 11:00 A.M. The mother stated she asked the sibling to wake up the SC to start getting ready for their outing. The mother said once the sibling was unable to awake the SC she went to the room, and when she turned the SC over, she felt the SC's body was very cold and heavy. The mother said she picked up the SC and when she realized the SC was dead, she began to yell, and ran out of the home for assistance. The mother said she called the father, but was unable to explain what was going on in the home because she was screaming. The mother said she and a neighbor attempted CPR, but the SC did not respond. The mother said EMS transported the SC to the hospital, but the medical staff's efforts to resuscitate the SC were to no avail. The father met the family at the hospital.

ACS contacted family members, the children's pediatrician and the children's school and no one had concerns about the parents' ability to care for the children.

On 10/24/19, ACS unfounded the report.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: There was no documentation of an MDT investigation; however, the investigation adhered to previously approved protocols for joint investigations.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050695 - Deceased Child, Female, 8 Yrs	050698 - Mother, Female, 37 Year(s)	DOA / Fatality	Unsubstantiated
050695 - Deceased Child, Female, 8 Yrs	050697 - Father, Male, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
050695 - Deceased Child, Female, 8 Yrs	050698 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
050695 - Deceased Child, Female, 8 Yrs	050697 - Father, Male, 42 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐

Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐

Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

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? No
Explain:
There were no immediate services needed in response to the fatality. However, ACS offered bereavement services which the parents declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There was no immediate services needed in response to the fatality. However, ACS offered bereavement services and funds for the SC's burial, but the parents refused.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/02/2017	Deceased Child, Female, 6 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 6 Years	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Father, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The report alleged the parents were physically violent towards each other and hit the children with excessive force. The report also stated the most recent incident occurred on 1/2/17 in the morning, and that the NYPD had responded to the

home in the past. It was alleged there were loud thumps, a child screaming and wailing saying, "no, no" while being hit. Further, it was reported these incidents usually occurred in the mornings before school.

Report Determination: Unfounded | **Date of Determination:** 02/24/2017

Basis for Determination:
ACS unsubstantiated the allegation of IG of the children by the parents and cited the children denied they were physically disciplined by the parents and were observed to have no marks or bruises throughout the investigation. ACS also cited the parents provided the children all their basic needs such as food, shelter, clothing, education, and supervision.

OCFS Review Results:
ACS initiated and completed a timely investigation, and issued the proper NOEs. However, the investigation was not thorough as some relevant collateral contacts were not made such as: superintendent, the NYPD, the school. Others were contacted via fax. The case documentation did not reflect all questions in the RAP were addressed during the investigation. ACS did not properly complete the safety assessments or fully explored the issues of abuse/DV that was a pattern in the previous investigations. In addition, the local protocol was not completed. Previous investigation disclosed the sibling had previously witnessed the father hit the mother.

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

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
ACS did not properly complete the template for the safety assessments. In addition, the safety decisions and safety factors were not consistent with the case documentation.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(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:
Adequacy of Risk Assessment Profile (RAP)
Summary:
ACS did not fully complete the RAP, as the father was not listed as the secondary caretaker.
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:
Contact/Information From Reporting/Collateral Source
Summary:
ACS made some relevant collateral contacts, but did not contact the NYPD or the school. The building superintendent was interviewed; however, relevant information was not obtain. These collaterals could have been used to explore the specific allegations documented in the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/14/2016	Deceased Child, Female, 6 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 7 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 6 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR registered a report alleging the parents were physically and verbally abusing to the children. The report alleged the abuse occurred nearly every day; and the parents were heard screaming at the children and thrashing them around. It was also alleged there were "things" being thrown around in the home, and the children were heard screaming and crying.

Report Determination: Unfounded **Date of Determination:** 04/22/2016

Basis for Determination:
ACS unsubstantiated the allegation of IG of the children by the parents. ACS based their determination on the children's interviews in which they denied being hit by the parents. ACS also cited that unannounced visits were made to the home and there was no screaming coming from the apartment. Further, the children did not have any marks or bruises throughout the investigation.

OCFS Review Results:
ACS did not conduct a thorough investigation as information was gathered, but not fully explored. ACS made some relevant collateral contacts but made no inquiry to assess the parents' demeanor and/or ability to care for the children. There was no adequate follow up with the conflicting information provided by neighbors. Information in the safety was not consistent with the case circumstance documented in the investigation.

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
ACS did not properly complete the template for the safety assessments. In addition, the safety decisions and safety factors were not consistent with the case documentation. ACS added subheadings to the template not relevant to the safety assessment.

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

Action:
ACS did not properly complete the template for the safety assessments. In addition, the safety decisions and safety factors were not consistent with the case documentation.

Issue:
Failure to provide notice of report

Summary:

The CONNECTIONS' event list did not reflect the Notices of Existence 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 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/11/2016	Deceased Child, Female, 5 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 5 Years	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

The SCR registered a report alleging there was ongoing DV between the parents, and the most recent incident allegedly occurred on 1/10/16. The report alleged the NYPD had responded to the home due to the reported incident. It was also alleged that "someone" in the apartment was getting thrown around and the children were screaming. The SCR registered a report with similar allegations on 2/4/16 and was closed as a duplicate on 2/10/16.

Report Determination: Unfounded | **Date of Determination:** 03/11/2016

Basis for Determination:

ACS unsubstantiated the allegation of IG of the children by the parents based on finding no credible evidence. ACS' interviewed the neighbors and they denied hearing screams coming from the home. In addition, the family denied the allegations of DV and ACS observed positive interaction between the parents. ACS also explored whether the family had any domestic incident report (DIR) filed with the NYPD, and none was found.

OCFS Review Results:

ACS initiated and completed a timely investigation and made relevant collateral contacts with the neighbors, school and the pediatrician. ACS contacted the NYPD and confirmed there were no DV reports. However, ACS did not fully explore the frequency the NYPD responded to calls to the family's apartment, obtain and assess the family dynamic, or the hours they responded to the home. Based on the determination narratives, ACS did not consider the sibling's account where he reported he had in the past witnessed the father hit the mother and arguments between the two. In addition, one neighbor was adamant about her concerns of abuse and noted she had also called the police.

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

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

ACS did not fully explored the allegation of DV as the sibling witnessed one incident in the past where the father his the mother. The parents completed the local protocol and denied any DV between them. Also, although there were no DIRs, ACS did not explore further the calls received by the local precinct which led to the NYPD responding to the home.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

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:
ACS noted there were no safety factors, however, this was not consistent with the case documentation. ACS had collaterals with neighbor and the sibling who mentioned there was DV in the past and more recently. Also, the documentation reflects that DV was a concern as this was noted in the 7-day safety assessment and ACS provided the mother with DV resources.
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:
Failure to provide notice of report
Summary:
The CONNECTIONS event list did not reflect a Notice of Existence was issued to the parents.
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.

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

The family had no CPS history during this period.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

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