Child Fatality Report

Report Identification Number: NY-23-026

Prepared by: New York State Office of Children & Family Services

Issue Date: Aug 15, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 17 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 02/26/2023
Initial Date OCFS Notified: 02/28/2023

Presenting Information

On 2/27/23, the Administration for Children's Services (ACS) learned of the death of the 17-year-old female subject child that occurred on 2/26/23. There was an open CPS investigation at the time of the death, which began on 2/22/23. The child was hospitalized with liver failure and the report alleged the mother was intoxicated at the hospital and unable to make medical decisions for the child. ACS notified the New York City Regional Office of the death via the 7065 Agency Reporting Form.

Executive Summary

On 2/22/23, ACS received an SCR report regarding the 17-year-old being hospitalized with acute liver failure. The report additionally alleged that the mother was intoxicated while at the hospital and was unable to understand the child's condition and make medical decisions. ACS completed visits to the hospital to assess the child and was in communication with medical personnel regarding her condition. The child succumbed to her condition and died on 2/26/23. There was no SCR report regarding the death, as ACS gathered additional information and determined there was no reason to suspect abuse or maltreatment by the mother led to the death of the child. At the time of her death, the child resided with her mother, mother's partner and 5-year-old sibling.

Upon learning of the incident, ACS gathered information from the mother and hospital personnel. It was learned that the child displayed symptoms of illness, including vomiting, stomach pain, and a rash on her arms. On 2/18/23, the child's body broke out in blisters and the mother called 911. Emergency medical services responded and transported the child to the hospital. The child was diagnosed with acute liver failure and transferred to another hospital for a higher level of care and was admitted. The child's condition worsened and she died on 2/26/23. The child had no underlying medical conditions and the attending physician suspected a viral infection may have contributed to the liver failure. The mother reported drinking alcohol due to the stressors of the child's condition and it was confirmed the mother presented to the hospital inebriated and was declined entry. After that incident, the mother was appropriate, was at the child's bedside, and there were no other concerns reported. The sibling was being cared for by a babysitter while the mother stayed at the hospital with the child.

The death was referred to the medical examiner's office; however, they declined the autopsy due to the death appearing to be complications from a natural disease and there were no suspicious injuries or substance use. The hospital elected to perform an autopsy and the final results were pending at the time this report was written.

ACS held a child safety conference and determined family court action was not necessary. Due to concerns about the mother's lack of engagement in her alcohol misuse treatment, ACS opened a preventive services case to monitor the mother's compliance. The family was provided with information on grief counseling and offered funeral assistance.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
It was determined the child's death was not the result of maltreatment by the mother, therefore there was no SCR report regarding the fatality and the completion of safety assessment tools was not required.

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

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

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

Explain:
ACS opened a preventive services case for the family.

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: 02/26/2023 **Time of Death:** 06:53 PM

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

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☒ Other: Hospitalized

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	17 Year(s)
Deceased Child's Household	Mother	No Role	Female	39 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	49 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)

LDSS Response

On 2/22/23, ACS was notified by an SCR report that the child was hospitalized with acute liver failure. The child was hospitalized until her death on 2/26/23. ACS contacted the hospital, interviewed the mother, assessed the safety of the sibling, visited the hospital, spoke with the pediatrician, and offered services in relation to the death.

ACS spoke to the mother, who reported the child became ill over the course of four days, with vomiting, fever, and abdominal pain. The mother monitored the child's condition at home until 2/18/23 when the child's body became engulfed in blisters and the mother called 911. The child was brought to the hospital and diagnosed with liver failure. The child was transferred to another hospital for a higher level of care. The child's diagnosis was unforeseen and unprovoked. The mother denied there were any hereditary factors associated with the diagnosis. The mother denied any medical concerns for the maternal family. The mother admitted she attempted to make a visit to the hospital while inebriated. The mother reported she has been overwhelmed due to the child's sudden illness, her ongoing custody battle with the sibling's father, and her partner's medical concerns. The mother reported she drank 3 glasses of vodka before arriving at the hospital. The mother reported the sibling was with a babysitter at that time.

ACS attempted to speak with the mother's partner; however, he initially declined to be interviewed and ultimately died during the investigation due to medical issues. The sibling was interviewed and did not report any safety concerns. ACS did not document efforts to contact the sibling's father, though contact information was available for him in prior CPS investigations. The mother reported having no contact with the father of the subject child.

ACS maintained contact with the child's medical team during the investigation and following the child's death. The hospital staff reported the child was very sick upon being admitted and she was transferred from two hospitals to get advanced care. The child had a severe inflammatory disease that affected her internal organs and skin, resulting in liver and kidney failure. There were numerous inflammatory markers in the child's blood that may have caused the inflammation. The child had no underlying medical conditions and the physician reported it was possible for the child's condition to occur without such. It was suspected the child may have had a viral infection which also could have led to her liver failure. In speaking with the child's pediatrician, there were no concerns reported for the child's care and no medical concerns for the child. Hospital staff reported the death was due to medical complications and it was not due to abuse or neglect by the mother.

ACS gathered information from the mother's alcohol misuse treatment provider. It was reported the mother had been

attending; however, continued to test positive for alcohol and her attendance had declined over the last month. The mother agreed to ongoing preventive services with an agency contracted by ACS to monitor her compliance with her treatment.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

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

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?	☐	☐	☒	☐
Explain: As there was no SCR report surrounding the fatality, the completion of safety assessments was not required; however, ACS documented an assessment of the sibling's safety following the death.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/22/2023	Deceased Child, Female, 17 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 17 Years	Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged that the mother misused alcohol. On 2/21/23, the 17-year-old subject child was transferred from one hospital setting to another with acute liver failure. The mother went to both hospitals intoxicated. The mother smelled of alcohol, her speech was slurred, and she was unable to make eye contact. The mother was unable to comprehend the extent of the child's medical condition and was unable to make imperative medical decisions.

Report Determination: Unfounded **Date of Determination:** 04/20/2023

Basis for Determination:
ACS unsubstantiated the allegations as they determined that the mother called 911 when the child began to feel ill. The child was taken to the emergency room and the mother made a plan for the sibling's care. ACS determined that although the mother presented to the hospital under the influence of alcohol, there was no impact on the child as she was hospitalized. The mother was at the hospital with the child when she died and appeared coherent and alert during the investigation. The mother submitted to a drug screen on 3/9/23 and the results returned negative for all substances and alcohol. The family was referred to preventive services.

OCFS Review Results:
ACS completed interviews with the family and collaterals regarding the allegations. The child died during the investigation, and ACS gathered information from medical collaterals to determine the death was not the result of abuse or maltreatment by the mother. ACS spoke to the mother's substance misuse treatment provider, who reported the mother continued to test positive for alcohol. ACS determined that court intervention was not necessary; however, opened a preventive services case to monitor the mother's engagement in treatment and provide services regarding the fatality. The record did not reflect efforts to contact and notify absent parents.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
ACS did not document efforts to contact the sibling's father regarding the investigation, though contact information was

available for him in prior CPS investigations. The mother reported having no contact with the father of the subject child.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

ACS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/14/2022	Sibling, Female, 5 Years	Mother, Female, 38 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 5 Years	Mother, Female, 38 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:

An SCR report alleged that the sibling had a long mark across her neck which started on the left side and spanned to the right side across the front of her neck. There were concerns that the injury appeared to be suspicious in nature. There were concerns that the injury was inflicted by her mother as she had a history of being physically abusive toward the sibling.

Report Determination: Unfounded | **Date of Determination:** 02/11/2023

Basis for Determination:

ACS determined there was no fair preponderance of evidence to support the allegations. The mother indicated the sibling accidentally wrapped a ribbon around her neck in an attempt to construct a necklace and the string got caught on an object in the home, where it became tightened leaving a mark at the location. The sibling was interviewed on several occasions regarding the bruise on her neckline area. The sibling maintained a legible explanation of how the bruise was received. The sibling was interviewed at the CAC and her explanation remained consistent.

OCFS Review Results:

During the investigation, ACS interviewed the sibling at the CAC, interviewed the mother and subject child, spoke to the sibling's father via telephone, contacted collaterals, and completed home visits. ACS learned that the mother was in compliance with her substance abuse treatment. There were no concerns reported for the children's safety. Appropriate services were discussed and offered and the investigation was closed within 60 days of receipt of the SCR report.

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)
02/15/2022	Deceased Child, Female, 16 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 16 Years	Mother, Female, 38 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 38 Years	Burns / Scalding	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 38 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 38 Years	Lack of Supervision	Unsubstantiated	

	Sibling, Female, 4 Years	Mother, Female, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged that the mother misused alcohol to the point of intoxication in the home daily in the presence of the children. In December 2021, the 4-year-old sibling sustained a burn to her chest area while in the care of the mother. The mother had no explanation for how the sibling was burned. The mother passed out from intoxication leaving the 4-year-old without adult supervision. The mother behaved in an out-of-control manner while intoxicated allowing unrelated adults to frequently come and go from the home causing the subject child to feel uncomfortable in the residence.

Report Determination: Indicated | **Date of Determination:** 04/01/2022

Basis for Determination:
ACS substantiated IG and PD/AM against the mother regarding the child, as they determined the child was being emotionally impacted by the mother's drinking. The child reported the mother was drinking to the point of impairment and the child was worried for the sibling when the mother drank. ACS unsubstantiated the allegations regarding the sibling because they reported the concerns were already investigated in the 12/21/21 investigation. ACS did seek a legal consult and were advised to hold another child safety conference and return to legal with the results. Following the conference, ACS did not seek to file, as the mother ultimately agreed to an outpatient treatment program.

OCFS Review Results:
Though the mother agreed to outpatient, she had a history of alcohol misuse and was testing positive for high levels of alcohol during the investigation. The subject child reported current alcohol misuse by the mother, resulting in the child having to monitor the care of the sibling. The mother was recommended for detox and left against medical advice. The mother completed intake for outpatient substance abuse treatment; however, had not begun individual counseling sessions. Despite this, ACS closed their CPS investigation and preventive case with no way to monitor the mother's compliance with her treatment program and the safety of the children.

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

Issue:
Appropriateness of allegation determination

Summary:
Though allegations regarding the same concerns were substantiated in the 12/21/21 concurrent investigation, the same allegations were unsubstantiated regarding this SCR report.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the New York City Regional Office if further guidance is needed.

Issue:
Decision to close case to protective services

Summary:
Despite ongoing safety and risk concerns regarding the mother's alcohol misuse and the mother's minimal cooperation with services, ACS closed their CPS investigation with no way to monitor the mother's compliance with her outpatient treatment program or monitor the safety of the children.

Legal Reference:
18 NYCRR Section 432.2(c); CPS Manual IV I.1

Action:
A case may be closed with the State central register only when the local child protective service can show that all children in the household are assessed to be safe despite the withdrawal of controlling interventions that may have been provided to protect the children and it is concluded that the risk of future abuse or maltreatment has decreased sufficiently.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/21/2021	Sibling, Female, 4 Years	Mother, Female, 37 Years	Burns / Scalding	Unsubstantiated	Yes
	Sibling, Female, 4 Years	Mother, Female, 37 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 37 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report alleged that the mother consumed large amounts of alcohol on a regular basis. When the mother was impaired, it affected her ability to provide adequate care and supervision to the then 4-year-old sibling. On 12/15/21, the mother passed out after consuming too much alcohol and left the sibling unattended in the home. The sibling was trying to open up one of her toys with a pair of sharp scissors during this time but was not injured. On 12/21/21, the sibling had a visible burn to the left side of her chest. The mother was aware of the injury but failed to provide an explanation for how it was sustained.

Report Determination: Indicated | **Date of Determination:** 02/18/2022

Basis for Determination:
ACS substantiated PD/AM, LS, and IG against the mother. In interviewing the mother, ACS determined the sibling was burned accidentally with a cigarette while the mother had friends over and was intoxicated. ACS unsubstantiated the BURN allegation as they determined the burn was sustained accidentally and the mother did not intend to harm the sibling.

OCFS Review Results:
ACS coordinated a joint investigation with law enforcement, completed a CPS history check, interviewed the children and mother, and spoke to collaterals. The sibling reported she sustained the burn when she was dancing in the kitchen and the mother's friend's cigarette burned her. The friend and mother denied burning the sibling. The subject child reported concerns about alcohol use to the point of intoxication by the mother. ACS opened a preventive services case to refer the mother for a substance use evaluation. ACS incorrectly determined the BURN allegation, as the burn resulted from an act of omission of the mother when she failed to adequately supervise the sibling.

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

Issue:
Appropriateness of allegation determination

Summary:
ACS incorrectly unsubstantiated the BURN allegation. The burn resulted from an act of omission by the mother when she failed to adequately supervise the sibling. The mother admitted to being impaired when the sibling was burned.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the New York City Regional Office if further guidance is needed.

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

In 2010, the mother had an indicated CPS investigation after she assaulted shelter staff while intoxicated with the subject child present.

In 2018, the mother had an unfounded CPS investigation regarding concerns about her drinking to the point of intoxication while caring for the children. The mother admitted to drinking but not to the point of impairment and tested negative twice for all substances during the investigation.

Preventive Services History

Between 2/9/10 and 6/2/11, ACS had an open preventive services case with the mother after she assaulted shelter staff while intoxicated. The mother was arrested and the subject child resided with the maternal uncle. The mother maintained her sobriety, obtained housing, and was meeting the child's needs. The mother was referred to relapse prevention and the case was closed.

Between 2/22/21 and 4/1/22, ACS opened a preventive services case due to concerns for the mother's untreated substance misuse and the sibling sustaining a bruise. Despite ongoing safety and risk concerns regarding the mother's alcohol misuse and the mother's minimal cooperation with services, ACS closed their preventive services case after the mother declined ongoing services but agreed to outpatient substance misuse treatment and attended intake. The mother had a history of noncompliance, including leaving detox against medical advice during the preventive case. The safety of the sibling appeared to be reliant on the presence of the subject child in the event the mother was intoxicated and unable to provide adequate supervision. With the closure of the preventive case, there was no way to monitor the mother's compliance with her outpatient program in which she attended intake or monitor the safety of the children.

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