NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-078 **Prepared by: New York City Regional Office**

Issue Date: 4/11/2016

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
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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 09/21/2015
Initial Date OCFS Notified: 09/21/2015

Presenting Information

On 9/21/15, the SCR registered a report alleging that the BM left the 2 month-old SC sleeping face up on a bed and left the room for "no more than a couple minutes." The BM returned and found the SC in the same position but the SC was not breathing. The BM attempted CPR and contacted EMS. The SC was transported to the hospital and pronounced dead at 8:22 A.M. The SC was diagnosed with a pre-existing medical condition; however, it was not believed to have caused her death. The role of the 7-year-old sibling was unknown.

The SCR later received additional information noting that the SC was fed at 4:00 A.M, the BM checked the SC at 6:00 A.M. and she was fine. At 7:00 A.M, the SC felt warm but was not moving. The BM initiated CPR and had the nurse from her residence call 911. The FDNY arrived and continued CPR; however, the SC was DOA. Due to the SC's pre-existing condition, there was no reason to suspect any abuse or maltreatment.

Executive Summary

The SC was 2 months old when she died on 9/21/15. The ME listed the cause of death as undetermined (bed sharing in adult bed with soft bedding) and the manner of death as undetermined.

The family had an extensive history with ACS and Family Court dating back to 1997. The mother had two other children who were removed from her care and later adopted.

On 2/28/13, ACS filed an Article 10 Petition at the Bronx Family Court on behalf of the 7-year old surviving sibling due to medical neglect. The sibling was remanded and placed in the custody of the Commissioner of ACS under the auspices of New York Foundling (NYF). On 5/21/14, the petition was resolved with an ACD of the mother's case and a finding of neglect for the SC's father. The sibling was returned to the mother with COS supervision by ACS which ended on 5/20/15. At the time of the fatality, the family had an open PPRS case with NYF that began on 5/26/15.

The SC was born premature and was diagnosed with a number of medical conditions, which caused her to remain hospitalized until 8/15/15 when she was discharged in good health. The sibling had developmental delays and a medical condition that required treatment and daily in home nursing services.

On 9/21/15, the SCR registered a report with allegations of DOA/Fatality and Inadequate Guardianship of the SC by the mother. ACS later added the allegation of IG of the sibling by the mother.

On 9/21/15, the sibling's nurse arrived at the home at 7:00 A.M. At about 7:15 A.M. nurse noticed the SC looked "different" and questioned the mother about the SC's appearance. The mother placed the SC on the bed, and they realized the SC was not breathing. The mother administered CPR while the nurse called 911. EMS arrived to the home at 7:24 A.M. and transported the SC with the mother to Lincoln Hospital where the SC was pronounced dead at 8:22 A.M. The sibling remained with the nurse who escorted him to Columbia Presbyterian Hospital for his medical treatment.

ACS assessed the safety of the sibling within the required timeframe and had concerns about his safety based on the mother's history. However, none of the service providers from the residence, visiting nurses, or therapists had concerns about the mother's ability to care for the SC or sibling. In addition, the NYF documentation indicated that the sibling appeared well cared for; the family was seen in the home on a weekly basis.

On 9/23/15, ACS held an Initial Child Safety Conference and determined that a petition should be filed in Family Court for the sibling to be paroled to the mother with COS. However, FCLS delayed and ultimately did not file the petition as there was substantial compliance by the respondents with the service plan and court orders.

On 11/20/15, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the mother noting there was no credible evidence to support that the mother's actions caused the SC's death or that she did not take appropriate care of the SC. ACS received the cause and manner of death from the ME on 1/5/16.

Although the basis for adding the allegation of IG was not explained, ACS substantiated the allegation of IG of the sibling citing that the mother disengaged in clinical services and medication regimen and became so distraught that she was seeking respite services for the sibling. An Administrative Review was requested and the decision was amended and legally sealed on 2/18/16.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** No,sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** No

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? 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

Issue:	Appropriateness of allegation determination
Summary:	ACS' decision to SUB IG of the sibling by the BM was not based on the case circumstances. The BM discontinuing her clinical services and requesting respite for the sibling did not present any concerns of maltreatment.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS 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 correction action 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 Notices of Existence were not provided to the PS or non custodial parent.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS 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 correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/21/2015 **Time of Death:** 08:22 AM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: 07:22 AM
Did EMS to 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
How long before incident was the child last seen by caretaker? 1 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not

impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	No Role	Male	49 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	7 Year(s)

LDSS Response

Following the 9/21/15 fatality report, the SCR also received additional information noting that due to the SC's pre-existing condition, there was no reason to suspect any abuse or maltreatment.

The SC was born premature and diagnosed with a number of medical conditions; she remained hospitalized until 8/15/15. Upon discharge the SC was deemed to be in good health. The sibling had a medical condition that required nursing services in the home seven days a week.

According to the BM, on 9/21/15, she fed the SC at 4:00 A.M. and then checked the SC at 6:00 AM at which time the SC was "doing fine." The BM said she left the SC lying face up on her (BM's) queen size bed, and then went to prepare the sibling's breakfast and ready him for a medical appointment. There was no description documented concerning the bed or the items, if any, on the bed. Additionally, the notes did not specify where the SC slept overnight, as a bassinet was observed in the mother's room.

The sibling's nurse arrived at the home at 7:00 A.M. and the BM returned to check the SC. The nurse indicated that she was attending to the sibling who was going from the kitchen to the living room where the BM had her bed. At about 7:15 A.M., the nurse noticed the SC looked "different" and questioned the BM about the SC's appearance. The BM said that the SC was warm, but she (SC) was not breathing. The BM administered CPR while the nurse called 911. EMS arrived to the home at 7:24 A.M. and transported the SC with the mother to Lincoln Hospital where the SC was pronounced dead at 8:22 A.M. The sibling remained with the nurse who escorted him to Columbia Presbyterian Hospital for his medical treatment.

ACS learned that the BM was trained in CPR prior to the SC being discharged from the hospital. However, it was not confirmed whether she received any information on safe sleep practices. The SC's BF was not home, as he was not living with the family due to an unrelated problem he had at the complex, but he was allowed to visit regularly.

The NYPD made no arrest and found no criminality involved in the SC's death. The ME indicated there was no trauma to the SC's body; the lividity in the anterior of the body, indicated the SC was face down when she died. The ME was unable to say how long the SC was dead prior to discovery.

ACS assessed the safety of the sibling within the required timeframe and had concerns about his safety based on the

mother's history. However, none of the service providers from the residence, pediatricians, visiting nurse or therapists had concerns about the BM's ability to care for the SC or sibling. The NYF indicated that the sibling appeared well cared for, and the family was seen in the home on a weekly basis.

On 9/23/15, ACS held an ICSC and determined that a petition should be filed in Family Court for the sibling to be paroled to the BM with COS. FCLS ultimately decided against the petition as there was substantial compliance by the respondents with the service plan and court orders.

On 11/20/15, ACS UNSUB the allegations of DOA and IG of the SC by the BM noting there was no credible evidence to support that the BM's actions caused the SC's death or that she did not take appropriate care of the SC. ACS did not document if ther was any evidence to suggest that the child was sharing the bed with anyone else. ACS received the cause and manner of death from the ME on 1/5/16. The ME listed the cause of death as undetermined (bed sharing in adult bed with soft bedding) and the manner of death as undetermined.

ACS substantiated the allegation of IG of the sibling citing that the BM who had disengaged from clinical services and medication regimen had become so distraught that she was seeking respite services for the sibling. An Administrative Review was requested and the decision was amended and legally sealed.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
020701 - Deceased Child, Female, 2 Mons	020702 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
020701 - Deceased Child, Female, 2 Mons	020702 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
024081 - Sibling, Male, 7 Year(s)	020702 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:
N/A

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☐	☒	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving	☒	☐	☐	☐

siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed and placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: N/A				

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	Offered, but	Offered, Unknown	Needed but not	Needed but	N/A	CDR Lead to

	Death	Refused	if Used	Offered	Unavaliable		Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: N/A							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no immediate needs following the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate needs following the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
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)	Status/Outcome	Compliance Issue(s)
01/02/2013	5103 - Sibling, Male, 5 Years	5102 - Father, Male, 46 Years	Inadequate Guardianship	Indicated	Yes
	5103 - Sibling, Male, 5 Years	5102 - Father, Male, 46 Years	Lacerations / Bruises / Welts	Indicated	
	5103 - Sibling, Male, 5 Years	5101 - Mother, Female, 34 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The SCR registered a report alleging that the sibling was continuously observed with multiple bruises and the mother had no plausible explanation as to how they were sustained. On the day of the report, the sibling was observed with bruises on his neck, inside both ears and his left cheek.

Determination: Indicated | **Date of Determination:** 02/01/2013

Basis for Determination:
ACS substantiated the allegations of IG and LCW against the PS based on the child's disclosure to ACS and the CAC that the PS pulled his ears. The allegation of IG was unsubstantiated against the mother because the child adamantly denied that she hit him.

OCFS Review Results:
The sibling had developmental delays and recieved special education services with counseling at school. The child disclosed that the PS pulled his ears and was seen by doctors at the ER and interviewed by the CAC. The bruises were consistent with the child's account. However, ACS did not thoroughly explore the mother's role as she alleged did not notice the visible injuries on the child and gave numerous explanations as to how the child could have sustained the

bruises.

The PS stated that he was homeless, but this was not explored and the IC reflected that he resided at the case address.

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

Issue:
Failure to provide notice of report
Summary:
The CONNECTIONS event list reflects that no NOE was issued to the subjects of the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action 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' events list did not reflect that the NOI were issued to the subjects of the report.
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 correction action 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 allegation of IG against the mother who was the primary caretaker of the child and alleged she did not noticed the visible bruises on the child. She was unable to provide a plausible account to explain the child's bruises.
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 correction action 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)	Status/Outcome	Compliance Issue(s)
02/01/2013	5106 - Sibling, Male, 5 Years	5105 - Father, Male, 46 Years	Inadequate Guardianship	Unfounded	Yes
	5106 - Sibling, Male, 5 Years	5104 - Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	

Report Summary:

The SCR registered a report alleging that there was domestic violence between the mother and the PS. It was also reported that the was a history of the PS inflicting injury to the sibling. There was concerns that the mother failed to protect the sibling and continued to all the PS to remain in the home.

Determination: Unfounded | **Date of Determination:** 02/20/2013

Basis for Determination:
The allegation of IG was unfounded for the mother and the PS based on their account in which they denied the allegations of DV. ACS also cited that the child reported that he did not like the PS and lied "about what was going on." ACS also cited that there were no current police reports and the mother had never been seen with bruises. ACS did not take into consideration the previous report where the child was seen with bruises and had disclosed to ACS and CAC that they were inflicted by the PS.

OCFS Review Results:
ACS noted they were unable to merge the reports with the 1/2/13 investigation.

The BM and PS were both receiving clinical services and drug treatment. The SC disclosed to the source that there was DV between the BM and PS; however, he later denied the allegation to ACS. ACS contacted the source of the report, but did not ask questions concerning his contact with the BM or PS. In addition, ACS did not ascertain from the source what prompted the child's disclosure. ACS unsubstantiated the allegations mostly on the family's account and that there were no DIRs, but did not take into consideration the indication of the previous report where it was determined the PS was abusive to the child.

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

Issue:
Failure to provide notice of report

Summary:
The CONNECTIONS event list did not reflect that the NOE were issued to the subjects.

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 correction action 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:
Contact with the source as a collateral did not explore relevant issues concerning the DV that the 5-year-old sibling disclosed.

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 correction action 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)	Status/Outcome	Compliance Issue(s)

02/25/2013	5109 - Sibling, Male, 5 Years	5107 - Mother, Female, 34 Years	Inadequate Guardianship	Indicated	Yes
	5109 - Sibling, Male, 5 Years	5108 - Father, Male, 46 Years	Inadequate Guardianship	Indicated	

Report Summary:
The SCR registered a report alleging that the child was prescribed .5 mg of clonidine; however, the mother administered a higher dosage when the child misbehaved. The report noted that the mother ran out of medication when the child was supposed to have nine pills left. Therefore, the pharmacy would not fill a prescription until the due date of 3/1/13. There was concern that the child was off his medication.

Determination: Indicated | **Date of Determination:** 03/25/2013

Basis for Determination:
ACS substantiated the allegation of IG against the mother a the PS because they increase the child's medication intake without the approval of the psychiatrist and this left the child without medication for several days.

OCFS Review Results:
The BM admitted to increasing the 5-year-old's medication and taking medication from a neighbor whenever she had none left for the child. The BM was directed to take the child to the ER where he was given medication for one day. ACS removed the child from the home on 2/27/13 at which time the Specialist observed old feces in the foot of the child's pajamas and he also smelled of urine. He was observed with scratch marks on the left side of his face and neck area. The BM explained these were inflicted by another child at school.

ACS filed an Article 10 Petition of Neglect and the child was remanded to the custody of the Commissioner of ACS.

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

Issue:
Failure to Provide Notice of Indication

Summary:
The NOI was not issued for the subjects or the BF.

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 correction action 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 does not reflect that the NOE was issued to the subjects or the BF.

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 correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR	Alleged	Alleged	Allegation(s)	Status/Outcome	Compliance

Report	Victim(s)	Perpetrator(s)			Issue(s)
10/07/2014	5112 - Sibling, Male, 7 Years	5110 - Mother, Female, 34 Years	Lacerations / Bruises / Welts	Unfounded	Yes
	5112 - Sibling, Male, 7 Years	5111 - Father, Male, 47 Years	Lacerations / Bruises / Welts	Unfounded	
	5112 - Sibling, Male, 7 Years	5110 - Mother, Female, 34 Years	Inadequate Guardianship	Indicated	
	5112 - Sibling, Male, 7 Years	5111 - Father, Male, 47 Years	Inadequate Guardianship	Indicated	

Report Summary:
Family Court had paroled the 7-year-old child to the BM in May 2014; at the time of the report the family was under ACS' supervision.

On 10/7/14, the child arrived at school with a faded bruise to the right side of his cheek; earlier in the year he had a large bruise on his face. The child also defecated in class and when told the PS would be called he became "uncontrollable." When the school staff contacted the BM, she asked whether the child had blood in his stool. The BM reported she had seen blood in the child's stool, but did not recall an exact date. The BM did not have an explanation for the child's bruise and had not contacted the doctor about the child having blood in his stool

Determination: Indicated **Date of Determination:** 12/05/2014

Basis for Determination:
ACS substantiated the allegation of IG against the BM and the PS because it was determined the 7-year-old child was not being properly supervised as he said he hurt himself while jumping on his bed.

The allegation of LBW was unsubstantiated against the BM and the PS based on the child's account where he noted he sustained the bruises on his face when jumping on the bed. The child gave the same account on two occasions.

OCFS Review Results:
ACS conducted a joint interview with the child and NYPD. The child reported he sustained the bruise while jumping on the bed. Concerning the blood in the stool the BM said she observed on an unspecified date, ACS recommended that the BM take the child to the doctor. This was not done during the investigation period. ACS contacted the service providers for family and confirmed the parents were adhering to the Family Court orders. The BM stated she and the PS were separated and later noted they were back together. ACS was aware the PS was attending his programs but did not attempt to see him there or while he visited the home.

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

Issue:
Failure to Provide Notice of Indication

Summary:
The NOI was not issued for the PS or the non-custodial parent.

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 correction action 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 PS or the non-custodial parent.
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 correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
ACS made no relevant efforts to interview the PS who was the subject of the report. The PS could have been contacted at his program or when he visited the home.
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 correction action 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 was completed timely; and the decision was appropriate. However, the selection of safety factors and comments were not all consistent with the case circumstances.
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 correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Investigation Conclusion Safety Assessments
Summary:
The safety assessment was completed timely; and the decision was appropriate. However, the selection of safety factors and comments were not all consistent with the case circumstances.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(b)
Action:
ACS 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 correction action 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 safety assessment was completed timely; and the decision was appropriate. However, the selection of safety factors and comments were not all consistent with the case 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 correction action 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)	Status/Outcome	Compliance Issue(s)
02/04/2015	5115 - Sibling, Male, 7 Years	5114 - Father, Male, 49 Years	Inadequate Guardianship	Indicated	Yes
	5115 - Sibling, Male, 7 Years	5113 - Mother, Female, 36 Years	Inadequate Guardianship	Unfounded	

Report Summary:

The SC was taken to the ER because he broke the tip of a pencil in his right ear at school. It was reported to the ER security that the PS was punching the SC on the head. The PS was held by the hospital's security and denied that he hit the SC. The BM reported that the SC was running around the ER "trying to touch" other children and the PS tried to calm the SC by holding the SC's arm against his body. The BM admitted the PS was talking loud to the SC, but did not hit him. The SC denied the PS hit him but stated that he was yelling at him. The SC was treated for pencil in his ear and was free of marks and bruises.

Determination: Indicated **Date of Determination:** 04/02/2015

Basis for Determination:

ACS indicated the report against the PS for the allegation of IG citing "inadequate supervision" based on the accounts of patients who reported they observed the PS hit and pulled the child's hair. ACS cited that the BM denied the PS hit the SC and reported that he yelled at the SC. ACS was unable to interview any witnesses.

ACS unfounded the report against the BM citing that she did not hit the SC. ACS failed to consider the BM's role of primary caretaker and the fact that she continued to expose the SC to the PS despite the past allegations of abuse that were substantiated against him concerning the SC.

OCFS Review Results:

ACS made relevant collateral contacts with the family members clinical and substance abuse providers, but did not assess the adults ability to care for the SC. The BM and ACS continued to refer to the PS as a support for the BM; however, he continued to display inappropriate responses towards the SC's behavior. There was no outreach to the SC' BF.

ACS obtained homemaking services for the BM; which towards the end of the investigation appeared to be helpful.

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

ACS selected safety decision #3 noting safety factors were present that placed the SC in immediate and impending danger of serious harm, but the safety factors selected were not consistent with the safety decision and the comments not relevant to the case circumstances.

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 correction action 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:

There was no Notice of Indication issued to the subjects or BF.

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 correction action 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 allegation of IG against the BM without considering that she was the primary caretaker of the SC and continued to expose the SC to the PS who was none to mistreat him.

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 correction action 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 Notice of Existence was not issued to the SC's BF.

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 correction action 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 has an extensive history with ACS dating back 1997 for allegations of PDRG, LSUP, IFCS, CDRG, and IG.

The mother had two TPRs involving two older children who were born with a positive toxicology for heroin. The mother had a long history of enrollments in methadone programs, relapses, unstable housing, domestic violence and mental

illness.

Concerning the now 7-year-old sibling, the mother was registered as a subject of three unfounded repots for PDRG, LSUP and IG. The reports indicate that the sibling was born with a positive toxicology for methadone. The history with the sibling reflects that the mother received clinical and drug treatment services and that she had secured assistant housing where she received supportive services. The SC's BF had no CPS history.

Known CPS History Outside of NYS

The family had no 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: 05/26/2015

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

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

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 SC's sibling was discharged from foster care with 12 months of COS by ACS. NYF's PPRS was provided after ACS completed their COS. Although the SC was born shortly after NYF's involvement, she was not added to the family

composition. The PPRS case remains open.

Required Action(s)

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

Issue:	Adequacy of case recording
Summary:	NYF failed to add the SC to the family composition; therefore, did not properly assess the needs of the child or include her in the FASP.
Legal Reference:	18 NYCRR 428.5(c)
Action:	ACS must obtain a CAP from NYF that identifies what action it has taken or will take to address this issue and submit it to NYCRO within 45 days.
Issue:	Adequacy of case recording in FASP
Summary:	The risk element questions in the FASP were not answered correctly. In addition, the second caretaker listed was incorrect as it listed the sibling's father who had no contact with the family as opposed to the SC's father.
Legal Reference:	18 NYCRR 428.6(a)
Action:	ACS must obtain a CAP from NYF that identifies what action it has taken or will take to address this issue and submit it to NYCRO within 45 days.

Preventive Services History

ACS referred the family to New York Foundling after the mother completed 12 month of court ordered supervision by ACS, which ended on 5/20/15. The PPRS services began on 5/26/16 and were active a the time of the fatality.

A review of CONNECTIONS revealed that NYF failed to add the SC to the family composition at the time of her birth and completed the RAP naming the sibling's father as the secondary caretaker, whom had no contact with the family and was unknown to the agency.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

The mother had two TPRS for her two older children who have been adopted.

On 2/28/13, ACS filed an Article 10 Petition at the Bronx Family Court on behalf of the surviving sibling due to medical

neglect. The mother was listed as the respondent. The sibling was remanded and placed in the custody of the Commissioner of ACS under the auspices of New York Foundling. On 5/14/14, the sibling was returned to the mother under Court Ordered Supervision.

Both the ACD and the dispositional order resulted in ACS supervision until 5/20/15, when the orders expired, based on apparent substantial compliance by the respondents with the service plan and court orders.

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:**
02/28/2013	Adjudicated Neglected	Article 10 Remand
Respondent:	020702 Mother Female 36 Year(s)	
Comments:	The sibling was in placement from 2/28/13 to 5/21/14 when he was discharged to the mother with COS.	

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