Child Fatality Report

Report Identification Number: NY-17-032

Prepared by: New York City Regional Office

Issue Date: Sep 19, 2017

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		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 26 day(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 09/06/2007
Initial Date OCFS Notified: 03/31/2017

Presenting Information

On 03/31/17, the SCR registered a report that alleged the mother had a baby boy who died from a lack of food while in the care of the parents. The report also alleged the father was being physically abusive to an 8-year-old sibling who sustained a scratch to her face. In addition, it was alleged the father was physically abusive to the mother in the presence of the 8-year-old sibling. The 6-year-old sibling had an unknown role.

Executive Summary

The SC was a one-month-old male who died on 9/6/07. The SC's death certificate listed the cause of death as complications of prematurity and the manner of death as natural.

On 3/31/17, the SCR registered a report with allegations of DOA/Fatality, Inadequate Food, Clothing, Shelter and Inadequate Guardianship of the SC by the parents, and Inadequate Guardianship and Lacerations, Bruises and Welts of the 8-year-old sibling by the father.

ACS initiated the investigation timely and learned the SC was born prematurely and was never discharged to the parents prior to his death. The SC died at the Brooklyn Hospital and no autopsy was performed.

The parents had two children after the SC’s death; in addition, the father had a child from a an extra-marital relationship.

The half-sibling’s mother and the father were known to ACS in 6 reports. The father was listed as a subject in two reports, with one being indicated. The father and the half sibling’s mother had a strained relationship which included incidents of domestic violence.

On 7/5/16, ACS filed an Article 10 Neglect Petition involving the female half sibling at the Bronx Family Court on 10/20/16 which listed her mother as the respondent. The half sibling was released to the non-respondent father on 11/2/16.

On 4/1/17, ACS assessed the surviving siblings were safe with the parents at the case address. The siblings were medically examined and cleared at Woodhull Hospital. There were no marks or bruises found or any indications of neglect or maltreatment on any of the children.

On 7/20/17, ACS received a subsequent report with allegations of Parent Drug/Alcohol Misuse, Lack of Supervision and Inadequate Guardianship of the three surviving siblings by the parents.

As of 8/21/17, ACS had not yet made a determination and the subsequent report also remained open.

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?** N/A

- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.

- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The safety assessment was not completed timely. The comments did not support the selected safety factors. The parent/caretaker actions were not relevant to the safety factors.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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:	Timely/Adequate Seven Day Assessment
Summary:	The safety assessment was not completed timely. The comments did not support the selected safety factors. The parent/caretaker actions were not relevant to the safety factors and there was no safety plan.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/06/2007 **Time of Death:** Unknown

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
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: hospitalized

Did child have supervision at time of incident leading to death? Unable to determine

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	26 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	51 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	48 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)

LDSS Response

ACS initiated the fatality investigation in a timely manner and interviewed the family members concerning the allegations.

According to ACS' documentation, it was disclosed the parents had a child who died and also that the father was abusive to the mother and the siblings. ACS was unable to obtain contact information to interview the source of this disclosure.

The parents reported they had a child in 2007 who was born prematurely and died in Brooklyn Hospital one month after his birth. The parents provided the SC's death certificate which confirmed this information. Based on the information obtained, he would have been older than his three siblings.

The three siblings were interviewed and based on the information they disclosed, it appeared the parents struck the children with a belt and/or their hands as a method of discipline. ACS did not observe any suspicious marks or bruises on the siblings. In addition, the children were medically cleared within 24 hours of the report at Brooklyn Hospital and none

of the children were seen with any indications of maltreatment.

The siblings also disclosed to ACS concerns regarding the parents' verbal and physical altercations; however, the siblings were not able to provide the dates of specific incidents. The parents denied the allegations and ACS did not find any domestic incident reports registered with the NYPD involving incidents between the parents.

ACS contacted the siblings' school and there were no concerns regarding the parents' care of the children. The school's staff indicated the siblings had no behavior, academic or attendance problems. However, the two older siblings had problems with their punctuality. The mother did not provide a valid reason for the siblings lateness and no plan for improvement was discussed.

According to the siblings' medical records, they all had their immunizations up to date and there were no medical concerns for any of them.

As of 8/31/17, ACS had not made a determination for the fatality investigation.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: There are no MDT's in the New York City region.

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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039749 - Deceased Child, Male, 26 Days	039753 - Mother, Female, 48 Year(s)	DOA / Fatality	Pending
039749 - Deceased Child, Male, 26 Days	039753 - Mother, Female, 48 Year(s)	Inadequate Guardianship	Pending
039749 - Deceased Child, Male, 26 Days	039752 - Father, Male, 51 Year(s)	Inadequate Food / Clothing / Shelter	Pending
039749 - Deceased Child, Male, 26 Days	039752 - Father, Male, 51 Year(s)	Inadequate Guardianship	Pending
039749 - Deceased Child, Male, 26 Days	039752 - Father, Male, 51 Year(s)	DOA / Fatality	Pending
039749 - Deceased Child, Male, 26 Days	039753 - Mother, Female, 48 Year(s)	Inadequate Food / Clothing / Shelter	Pending

CPS Fatality Casework/Investigative Activities

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

Additional information:
The SC died in 2007 and the fatality was not reported to the SCR.

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?	☐	☐	☒	☐
Explain:				

The safety assessments were not completed properly. The safety factors selected were not consistent with the case circumstances ACS documented.

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 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?	☐	☒	☐	☐
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 Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The SC died in 2007 and there were no siblings at the time of his death.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
The SC died in 2007 and the fatality was not reported to the SCR because the child died of natural causes and there were no suspicions of neglect or maltreatment of the SC by the parents.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The SC died in 2007 and the fatality was not reported to the SCR then because the child died of natural causes.

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? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections ☐ Had heavy alcohol use

☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ 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)
04/04/2015	Sibling, Female, 6 Years	Father, Male, 49 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Female, 6 Years	Father, Male, 49 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Male, 4 Years	Father, Male, 49 Years	Parents Drug / Alcohol Misuse	Indicated	
	Sibling, Female, 6 Years	Mother, Female, 46 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Female, 6 Years	Father, Male, 49 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 4 Years	Father, Male, 49 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 4 Years	Mother, Female, 46 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 4 Years	Mother, Female, 46 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Female, 6 Years	Mother, Female, 46 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 4 Years	Father, Male, 49 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 6 Years	Mother, Female, 46 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 4 Years	Mother, Female, 46 Years	Lack of Supervision	Unfounded	

Report Summary:
The SCR registered two reports dated 4/4/15 and 4/28/15 alleging the father and the mother of the SC engaged in physical altercations in the presence of the siblings. It was also alleged the parents became violent when under the influence of drugs and alcohol.

Determination: Indicated | **Date of Determination:** 05/12/2015

Basis for Determination:
ACS unsubstantiated the allegations against the parents, except for PD/AM against the father. ACS cited the father admitted to smoking marijuana and tested positive when he submitted to a drug screening.

OCFS Review Results:
NYCRO found the investigation was not thorough and at times deviated the focus of the family assessments to include the relationship of the father and his girlfriend. The directives provided for this investigation were not all completed.

Relevant collateral contacts were not all completed. The allegation determination was not properly supported in the narrative.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
ACS did not adequately respond to the questions in the RAP as they did not focus solely on this family composition and documented comments that were not consistent with their responses.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The comments for the selected safety factors did not explain how they impacted the parents' ability to care, supervise and/or protect the children in this household.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
The comments in the determination safety assessment for the selected safety factors did not explain how they impacted the parents' ability to care, supervise and/or protect the children in this household.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS did not make relevant collateral contacts such as housing management, relatives or pediatrician. The contact with the school was generalized and did not specify inquiries as it related to each parent's ability to care for the sibling.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken

or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/19/2014	Sibling, Female, 5 Years	Father, Male, 48 Years	Inadequate Guardianship	Indicated	Yes
	Sibling, Male, 3 Years	Father, Male, 48 Years	Inadequate Guardianship	Indicated	

Report Summary:
The SCR registered a report alleging the father and the mother of the SC engaged in a physical altercation in the presence of the then 5-year-old sibling. The report alleged the father hit the mother with a pan. The report noted the 5-year-old sibling did not sustain any injuries.

Determination: Indicated **Date of Determination:** 07/18/2014

Basis for Determination:
ACS substantiated the allegation of IG of the two siblings by the father. ACS cited the investigation revealed the parents engaged in a physical altercation while the children were present in the home. ACS also cited the 5-year-old sibling expressed she was afraid while the altercation was taking place.

OCFS Review Results:
NYCRO found this was not a thorough investigation, as there were insufficient collateral contacts. There was inaccurate safety and risk assessments and assessing the services needed. ACS did not interview the father or document any attempts to meet with him.

According to the mother, she and the father had a verbal altercation because he was going to leave the home to care for the child he had with his girlfriend. The mother said the 5-year-old sibling awoke but had not witnessed them arguing. The mother said she called the NYPD and the father left the home. There was no contact with the NYPD to corroborate the information.

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

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

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
ACS did not interview the father, and there were no efforts documented to contact him.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to provide notice of report
Summary:
The CONNECTIONS database did not reflect the Notice of Existence was not issued for the father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this investigation, 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:
The RAP was not properly completed and 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 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:
Timely/Adequate Seven Day Assessment
Summary:
ACS selected a safety decision noting there were safety factors that did not rise to the level of immediate or impending danger of serious harm. However, the selected safety factor was not 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, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

The family had no CPS history during this period.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Required Action(s)

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

Preventive Services History

ACS referred the family for counseling and PPRS. A FSS preventive was open on 5/5/15 and closed on 4/16/16. The case was closed as it was assessed the parents level of conflict was reduced and there were no safety factors that placed the children in immediate or impending danger.

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