Child Fatality Report

Report Identification Number: NY-17-147

Prepared by: New York City Regional Office

Issue Date: Jun 18, 2018

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☒ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 12 year(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 12/29/2017
Initial Date OCFS Notified: 12/29/2017

Presenting Information

The report alleged the 12-year-old SC was pronounced dead at his home at 8:57 A.M. on 12/29/17. The report alleged the 2-year-old sibling went to wake up the SC and he felt cold. The sibling alerted the mother and she contacted the PS who in turn called 911. The PS had left the home at about 5:00 A.M. to go to work. The report noted that based on the SC's lividity, he had been dead for at least six hours prior to the 911 call. The SC was an otherwise healthy child.

Executive Summary

The SC was 12 years old when he died on 12/29/17. The autopsy report listed the cause of death as acute intoxication due to the combined effects of buprenorphine and alprazolam and the manner of death accident (substance abuse).

At the time of the SC's death, the family had an active court case with the Richmond County Family Court (RCFC) and was under court ordered supervision (COS) with ACS' Family Services' Unit (FSU) who had referred the family to the Jewish Board of Children and Family Services agency (JBCFS) for PPRS.

On 12/6/16, ACS filed an Article 10 Neglect Petition on behalf of the children naming the PS as the respondent. The neglect petition was filed due to DV and excessive corporal punishment of the SC. Family Court released the children to the mother. A full stay away order of protection (OOP) was issued on behalf of the children and the mother against the PS. On 2/15/17, the PS had a 1051A hearing and the OOP was modified; he was allowed to return to the home but ordered not to use any physical discipline against the children.

On 12/29/17, the SCR registered a report concerning the SC's death. The allegations of the report were: DOA/FATL, CD/AM, PD/AM, LS and IG of the SC, and PD/AM and IG of the sibling. The subjects of the report were the mother and the PS. The SC's father resided out of the US; the PS was the father of the sibling. ACS made no effort to contact the SC's father.

ACS initiated contact with the family within the required time frame and interviewed them at the hospital. The surviving sibling was observed with no marks or bruises and ACS assessed her to be safe in the care of her parents. There were no safety concerns about the condition of the home.

The mother and the PS indicated the SC was last seen alive on 12/28/17 at about 8:00 P.M. at which time he locked himself in his room; which was not unusual. On 12/29/17, at about 8:30 A.M., the mother went to the SC's room and found him unresponsive. The mother said she called the PS at work, and then called 911. The PS said that after the mother hung up the telephone he also called 911 and a friend of the mother's for support. He then left his job to return to the home.

EMS responded to the case address and pronounced the SC dead at 8:58 A.M. The investigation revealed the mother and the PS were taking prescription drugs which were accessible to the SC. The autopsy report determined these drugs were found in the SC's system and in his closet.

ACS and the NYPD interviewed staff from the SC's school and several of his peers who revealed the SC was using drugs. ACS learned the mother had been informed by the school staff and the SC's peers of his drug use. However, she had not taken any action to address this issue.

On 1/29/18, ACS filed for an extension of the COS and the PS was excluded from the home as there were concerns about his use of illicit drugs.

A review of the FSU and PPRS' documentation revealed a lack of adequate supervision as ordered by the RCFC and poor safety and risk assessments. The issues of DV was minimized; which lead to a lack of appropriate services and protection of the SC.

On 3/28/18, ACS substantiated the allegations of DOA/FATL, CD/AM, L/S and IG of the SC by the mother and the PS. ACS cited the SC's autopsy determined the SC died of a drug overdose of medication prescribed for them and were left accessible to the SC. ACS also cited the mother and PS were aware of the SC's drug use, but did not provide adequate supervision or boundaries.

The allegation of PD/AM of the SC by the mother was unsubstantiated. ACS cited the mother always presented herself to be coherent and easy to engage.

The PD/AM and IG of the sibling by the PS was substantiated. ACS cited the PS's admission to using cocaine and his non-compliance with services after the SC's death.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

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:
This was not a thorough investigation, neither was ACS' monitoring of the home under the conditions of the COS.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The comments documented in the safety assessments did not support the selected safety factors as they did not explain how the caretakers actions or inactions impacted on their ability to care, supervise or protect the sibling.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The final risk rating was appropriate; however, questions in the RAP were not explored or had responses that were incorrect.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/29/2017 **Time of Death:** 08:57 AM

Time of fatal incident, if different than time of death: 08:58 AM

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
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? No - Not needed given developmental age or circumstances

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

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	12 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)

LDSS Response

ACS initiated the fatality investigation timely and made relevant contacts with the NYPD, medical staff, ME, neighbors, family members, school staff and peers.

On 12/29/17, ACS interviewed the mother and PS at the Staten Island University Hospital. The mother reported that on 12/28/17, the SC went out to ride his bicycle at about 11:30 A.M and was supposed to return to the home at 1:30 P.M. She stated the SC was not answering her calls; therefore, she went looking for him and brought him home about 4:30 P.M. There was no plausible explanation for the SC riding his bicycle for several hours while the temperature was 18 degrees Fahrenheit. The mother was not asked about the SC's demeanor when she brought him home. The mother noted FSU visited the home at 5:30 P.M. According to FSU documentation, the SC had been sleeping and appeared a "little sluggish" and his hands were cold.

The PS reported that on 12/29/17, he awoke around 3:30 A.M. and gave the sibling a bottle. The PS stayed awake and watched television as he would usually wake up at 4:45 A.M. to prepare for work. At approximately 8:30 A.M., the mother noticed the SC did not come out of his room for breakfast and did not respond when she knocked on his bedroom door. She used her key to enter his room and found the SC cold and unresponsive. The mother called for the PS then called 911. The PS corroborated the mother's account and stated she screamed the "SC was dead," and hung up the telephone. The PS said he also called 911 and left his job to return home. There was no timeline concerning these events.

The NYPD indicated the SC was pronounced dead at 8:58 A.M. by the EMS. ACS met with the ME at the hospital but the ME did not yet have a preliminary cause of death.

Initially, the home was considered a crime scene and the family stayed away for several days. However, NYPD found no evidence of any criminality regarding the SC's death.

ACS and the NYPD conducted a joint interview at the school with the SC's guidance counselor and peers. The peers revealed the SC was frequently "high" and was observed smoking marijuana. The peers stated the SC disclosed he used other illicit drugs as well as the mother's prescription drugs. However, the SC's toxicology did not reveal any trace of illicit drugs. There was no timeline documented concerning these events. The SC also told his peers he was frequently hit by the PS and his mother. The SC was also seen with large amounts of money.

According to the contact with the school staff sometime during the months of October/November 2017, the SC was found vaping with the other students in the school bathroom and his school grades were deteriorating. The peers also noted they told the mother the SC was getting "high." The documentation noted the mother said she "suspected" the SC was using drugs, but the collateral contacts reported she had been informed the SC was using drugs.

Neighbors stated the SC appeared to be afraid of the PS and the mother as his demeanor would change whenever they were nearby. Neighbors reported ongoing arguments between the mother and the PS. A neighbor provided a video tape where the mother was heard threatening the PS stating she would “hit herself and then call the police”. Neighbors indicated over hearing arguments about the PS using drugs.

The fatality investigation revealed high risk and safety concerns pertaining to these children even while under COS. ACS’ FSU and JBCFS were oblivious to the SC’s needs, violence and drug use that appeared to be present from the time of the referral for PPRS up until the SC’s death. The history of this case reflected the mother who was the SC’s primary caretaker, was not held accountable for her actions and/or lack thereof. Therefore, this impacted negatively on the quality and the recommendation of services. At the time of the determination, the parents were separating and the PS had been removed from the home.

On 3/28/18, ACS indicated the report.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: OCFS has no CFRT in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045287 - Deceased Child, Male, 12 Yrs	045671 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
045287 - Deceased Child, Male, 12 Yrs	045671 - Mother, Female, 30 Year(s)	Childs Drug / Alcohol Use	Substantiated
045287 - Deceased Child, Male, 12 Yrs	045672 - Mother's Partner, Male, 32 Year(s)	Childs Drug / Alcohol Use	Substantiated
045287 - Deceased Child, Male, 12 Yrs	045672 - Mother's Partner, Male, 32 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
045287 - Deceased Child, Male, 12 Yrs	045671 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
045287 - Deceased Child, Male, 12 Yrs	045672 - Mother's Partner, Male, 32 Year(s)	Lack of Supervision	Substantiated
045287 - Deceased Child, Male, 12 Yrs	045672 - Mother's Partner, Male, 32 Year(s)	DOA / Fatality	Substantiated
045287 - Deceased Child, Male, 12 Yrs	045672 - Mother's Partner, Male, 32 Year(s)	Inadequate Guardianship	Substantiated

045287 - Deceased Child, Male, 12 Yrs	045671 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
045673 - Sibling, Female, 2 Year(s)	045671 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
045673 - Sibling, Female, 2 Year(s)	045672 - Mother's Partner, Male, 32 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
045673 - Sibling, Female, 2 Year(s)	045672 - Mother's Partner, Male, 32 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:

The sibling was too young to interview concerning the events involving the SC's death.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate 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 comments documented in the safety assessments did not support the selected safety factors because they did not explain how the caretakers actions or inactions impacted on their ability to care, supervise or protect the sibling. The 24-Hour Safety Assessment and the safety modification were both approved on 1/5/18.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: The questions on the RAP instrument were not answered thoroughly. Several of the responses were not correct and others were not fully explored.				

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: The safety decision in this case was appropriate; however, the safety factors were not clearly identified and/or explained.				

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☒	☐	☐	☐	☐	☐	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☒	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☒	☐	☐	☐	☐	☐
Early Intervention	☐	☒	☐	☐	☐	☐	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☒	☐	☐	☐	☐	☐	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

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 was no immediate services required for the sibling. The family has an open services case with the JBCFS agency and ACS' FSU.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The was no immediate needed services for the caretakers. The family had an open service case with the JBCFS and FSU.

History Prior to the Fatality

Child Information

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

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)
10/16/2017	Deceased Child, Male, 12 Years	Mother, Female, 29 Years	Lacerations / Bruises / Welts	Unfounded	Yes
	Deceased Child, Male, 12 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 12 Years	Mother's Partner, Male, 33 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 2 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 2 Years	Mother's Partner, Male, 33 Years	Lacerations / Bruises / Welts	Unfounded	
	Deceased Child, Male, 12 Years	Mother's Partner, Male, 33 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:
The report alleged the mother and PS were hitting the SC with excessive force. The report alleged the PS struck the SC in the face causing marks and bruises. It was also alleged the SC was terrified and would run away from the home for protection. It was reported, the mother also struck the 2-year-old sibling leaving marks and scratches on the sibling.

ACS documented no marks or bruises were observed on the children. The report lacked sufficient relevant collateral contacts to properly explore the allegation of the SCR report. ACS documented the SC recanted the allegations made in the report, but the documentation did not reflect individual interviews with the SC.

Determination: Unfounded | **Date of Determination:** 12/21/2017

Basis for Determination:
ACS unsubstantiated the allegations of L/B/W and IG of the SC by the mother and the PS; and IG of the sibling by the mother.

ACS' determination did not properly support the allegations of the report as it pertained to each of the subjects for each of the children.

OCFS Review Results:
This was not a thorough investigation. Safety assessments were not completed properly and supervisory directives were

not completed during this investigation. The documentation was mostly a repetition of the report narrative and the family's history.

This family had been under Family Court supervision since 2016 and the relationship between the SC, the mother and the PS worsened. There were no relevant collateral contacts regarding the DV issue, anger management, drug use, parenting, family counseling or extracurricular activities for the SC. ACS did not utilize information from the school staff to explore the family dynamics.

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

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
ACS documented summaries from the investigations to support the selected safety factors in the 7-day assessment and did not clearly explain how the safety factors impacted the mother's or the PS's ability to care for the children.
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:
Overall Completeness and Adequacy of Investigation
Summary:
There was inadequate supervision and guidance. There were directives provided that were not completed. In addition, supervisory approval was given to safety assessment and investigation summary that were not properly completed. Red flags were not explored.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(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 Risk Assessment Profile (RAP)
Summary:
ACS did not properly explore or respond to several questions listed in the RAP.
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:
Appropriateness of allegation determination
Summary:
ACS unsubstantiated the allegations without completing a thorough investigation. The narratives to support the determination were not addressed individually as it related to each subject for each child.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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 and provided comments for safety factors that were not explored during this investigation. The comments consisted of information noted in past investigations.
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 Progress Notes
Summary:
The progress notes documented throughout the investigation mostly consisted of a repetition of the SCR narrative and the family's history.
Legal Reference:
18 NYCRR 428.5
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:
The family was receiving COS, but there was no collaterals to ascertain their involvement with services pertaining to the presenting problems: DV, anger management, dependence on prescription drugs, neighbors, and pediatricians. ACS did not explore the family dynamics based on the information provided by the SC's school.
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.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
ACS selected safety decision #1 for the determination safety assessment; however, the SC's behavior suggested the parents were unable and/or unwilling to properly care for the SC or provide adequate supervision. The SC repeatedly disclosed abuse, but recanted once the investigations were initiated.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/03/2016	Deceased Child, Male, 11 Years	Mother's Partner, Male, 32 Years	Parents Drug / Alcohol Misuse	Indicated	Yes
	Deceased Child, Male, 11 Years	Mother's Partner, Male, 32 Years	Swelling / Dislocations / Sprains	Indicated	
	Sibling, Female, 21 Months	Mother's Partner, Male, 32 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 11 Years	Mother's Partner, Male, 32 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 21 Months	Mother's Partner, Male, 32 Years	Lacerations / Bruises / Welts	Unfounded	
	Sibling, Female, 21 Months	Mother's Partner, Male, 32 Years	Parents Drug / Alcohol Misuse	Indicated	
	Deceased Child, Male, 11 Years	Mother's Partner, Male, 32 Years	Excessive Corporal Punishment	Indicated	
	Deceased Child, Male, 11 Years	Mother's Partner, Male, 32 Years	Lacerations / Bruises / Welts	Indicated	
	Sibling, Female, 21 Months	Mother's Partner, Male, 32 Years	Excessive Corporal Punishment	Unfounded	

Report Summary:
The mother and PS engaged in a physical altercation and the SC intervened. The PS struck the SC in the face then began throwing and breaking items in the home. Both children were present. The mother called the police and the PS fled; however; he was later arrested. The mother said the PS had been using cocaine for the past 3 months. The mother had concerns the PS would go to jail and informed the SC. The mother and the SC later recanted the allegations they made at the beginning of the investigation concerning the DV and the drug use.

The SC was taken to the hospital where he was observed to have redness and tenderness on his left cheek.

Determination: Indicated | **Date of Determination:** 02/01/2017

Basis for Determination:
ACS substantiated the allegations of IG and PD/AM of the children by the PS due to DV and the PS's behavior when under the influence of drugs.

ACS substantiated the allegations of EXCP, L/B/W and SWS of the SC by the PS due to DV and the SC's injury which caused him pain, discomfort and swelling. According to the medical examination.

ACS unsubstantiated the allegations of EXCP and L/B/W of the sibling by the PS because there was no evidence to support the substantiation of the allegations.

ACS should have added and substantiated the allegation of IG of the children by the mother for the DV due to her coaching the SC to recant his initial account.

OCFS Review Results:

This was not a thorough investigation. The mother and the PS both engaged in altercations in the presence of the children. The mother failed to adequately protect the children. The SC recanted his account after the mother discussed the possible jail sentence the PS would receive. The SC and mother both recanted their initial accounts and criminal charges were dismissed.

ACS filed an Article 10 Neglect Petition on behalf of the children naming the PS as a respondent. The children were released to the mother with COS. ACS failed to hold the mother accountable for her actions and/or lack thereof. ACS should have added and substantiated the allegation of IG of the children by the mother.

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

Issue:

Appropriateness of allegation determination

Summary:

ACS did not add and substantiate the allegation of IG of the children by the mother. The mother took no action to protect the children prior to the reported incident. In addition, she recanted her initial account and it appeared she coached the SC to do the same.

Legal Reference:

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

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:

Overall Completeness and Adequacy of Investigation

Summary:

The mother was the primary caretaker of the SC. ACS failed to hold the mother accountable for her actions and/or lack thereof. ACS should have added and substantiated the allegation of IG of the children by the mother.

Legal Reference:

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(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 information documented in the safety assessments did not include an assessment of the mother's ability to care/protect the children. Based on ACS documentation, she influenced the SC to recant his account after the reported incident. Although she called 911 on the day of the incident, she did not follow through with the criminal charges and recanted her account pertaining to the PS's drug use.

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:
Assessment as to need for Family Court Action

Summary:
ACS appropriately assessed the need of Family Court action; however, ACS failed to properly name the mother as a respondent. The mother was not willing to protect the children because she coached the SC to recant his account after the PS was arrested and also recanted her account pertaining to the drug use. She did not follow through with the criminal charges.

Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

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

[redacted]

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

The PS was listed as a subject in an unfounded SCR report dated 12/19/09. He was listed as an uncle in the family, but he did not reside in the home. ACS determined the PS was not a PLR.

The mother was listed as the subject of a report dated 6/23/13 for allegations of PD/AM, XCP and IG of the SC. The report was unfounded on 8/9/13. The PS was not listed in the family composition as he did not reside in the home and had only been dating the mother for 3 months. He also was not a PLR for the SC. The investigation revealed the PS assaulted the mother while under the influence of alcohol. The police were called; however, the mother did not follow up with legal action and decided to end their relationship.

Known CPS History Outside of NYS

The family had no known CPS history outside of 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: 12/06/2016

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 12/06/2016

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?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☐	☒	☐	☐

Closing

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

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
The family was under COS as a result of an Article 10 Neglect Petition and was referred to the JBCFS. The mother signed the service application on 1/20/17.

Required Action(s)

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

Issue:	Adequacy of Preventive Services casework contacts
Summary:	Although there was consistent contact with the family in the home, there was no substantive discussion concerning the family's circumstances or recommended services.
Legal Reference:	18 NYCRR 423.4(c)(1)(ii)(d)
Action:	ACS must obtain from JBCFS a Performance Improvement Plan and submit the plan within 45 days.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The safety assessments were not consistent with the case circumstances as the contact with the family was geared to the mother's concerns and did not address the safety and risk issues for which the family was referred.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	ACS must obtain from JBCFS a Performance Improvement Plan and submit the plan within 45 days.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:	The contact with the SC appeared superficial and there was no privacy when meeting with the SC. The contact with the mother and PS for couple's counseling was inappropriate for a case involving DV.
Legal Reference:	18 NYCRR 432.1 (b)(3)(ii)(a)
Action:	ACS must obtain from JBCFS a Performance Improvement Plan and submit the plan within 45 days.
Issue:	Coordination of Services
Summary:	There was no coordination of services between JBCFS and the FSU. The CP did not verify the services the family reported they were receiving.
Legal Reference:	18 NYCRR 432.2(b)(4)(i) and 432.2 (b)(4)(viii)
Action:	ACS must obtain from JBCFS a Performance Improvement Plan and submit the plan within 45 days.
Issue:	Adequacy of case planning
Summary:	The CP was not developing a case plan relevant for a DV case and began to conduct "couple's counseling" without the DV issues being addressed.
Legal Reference:	18 NYCRR 432.2 (b)(2)
Action:	ACS must obtain from JBCFS a Performance Improvement Plan and submit the plan within 45 days.
Issue:	Adequacy of Progress Notes
Summary:	The supervisory notes were entered late and did not contain any guidance or directives relevant to the presenting problems at the time of the referral.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must obtain from JBCFS a Performance Improvement Plan and submit the plan within 45 days.

Preventive Services History

ACS referred the family for PPRS with the JBCFS agency due to issues of DV, an active OOP that excluded the PS, and the COS. On 1/20/17, a JHV was made and the mother accepted services.

There was no ongoing assessment concerning the issue of DV after the PS was allowed to return to the home on 2/15/17. JBCFS' CP made frequent visits to the home, but the interviews with the mother were not substantive. There was no follow up with other alleged service providers concerning the PS's participation in a batterer's group, anger management, random drug screening or parenting skills. The documentation noted the mother disclosed suspicion the PS was using drugs, her problems with the SC's new school and allegations of the SC's "aggressive" behavior. These issues were minimized and not properly addressed. The CP began to make recommendations concerning the SC's behavior as reported by the mother without making an effort to interview the SC in a safe space. There was no significant discussion with the SC to assess his level of safety. The CP did not consider major safety and risk issues or provide an ongoing assessment of each family member. The CP's "couple's counseling" was not beneficial for the family due to the untreated drug use and DV.

The supervisory notes were entered late and did not redirect the CP to relevant issues pertaining to the family.

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:**
12/06/2016	There was not a fact finding	Order of Supervision
Respondent:	045672 Mother's Partner Male 32 Year(s)	
Comments:	On 12/6/16, ACS filed an Article 10 Neglect Petition on behalf of the children and named the PS as the respondent in the report. The judge granted ACS court ordered supervision and the PS was removed from the home with a stay away order of protection. The children were released to the mother with condition. The PS was allowed supervised visits at the field office. On 2/15/17, the OOP was modified and the PS returned to the home. On 4/3/18, ACS filed a new petition against the mother and the PS regarding the death of the SC and derivative neglect on the sibling. There is no fact finding date for the case. The sibling was released to the mother with court ordered supervision. The father's disposition was violated due to his cocaine abuse in addition a new petition was filed on him because of the drugs found in the SC's system. A full stay away OOP was issued against the PS on behalf of the sibling and he was only allowed supervised visits at the field office. The next court date will be held on 5/8/18 for a conference with the mother and the parent substitute.	

Have any Orders of Protection been issued? Yes	
From: 12/06/2016	**To:** 04/26/2019
Explain: The family had an order of protection issued in December 2016 to remove the PS from the home and it was modified in February 2017 to allow the PS to return to the home. The family was under COS. After the SC's death, ACS returned to court in January 2018 to have the PS again removed from the home.	

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