Child Fatality Report

Report Identification Number: NY-18-081

Prepared by: New York City Regional Office

Issue Date: Feb 04, 2019

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 08/05/2018
Initial Date OCFS Notified: 08/05/2018

Presenting Information

On 8/5/18, the SCR registered a report that alleged DOA/Fatality and IG of the SC by the SM.

According to the narrative of the report, the 2-month old male SC died while in the care of the SM. The SC was an otherwise healthy child with no preexisting medical conditions. He did not have any visible injuries at the time of his death.

Executive Summary

On 8/5/18, the 2-month-old male SC passed away while in the care of the SM. A review of the case records revealed that at approximately 7:00AM on 8/5/18, the SM fed and burped the SC. About 30 minutes later, the SM laid the SC on his back on the bed. The SM, the SC and the 2-year-old SS all slept on three twin-size beds pushed together against the wall. At about 1:50PM, the SM awoke and noticed the SC's eyelids were purple and he was unresponsive. The SM left the children in the family's unit and alerted shelter staff about the SC's condition. The staff called 911 and went to the room to perform CPR on the SC until EMS' arrival. Upon arrival, EMS took over and continued CPR on the SC. The SC and SM were escorted to the hospital. The hospital ER staff performed resuscitative measures to no avail. The SC was pronounced dead at 2:55PM. According to the final autopsy report, the SC's cause of death was bacterial bronchopneumonia, complicating resolving viral bronchiolitis. The manner of death was natural.

At the time of the fatality, the family resided in a shelter in Queens. The BF was not present in the home at the time of the SC's death.

On 8/5/18, ACS received the report and contacted the LE and medical staff. They did not report any signs of abuse to the SC. LE did not make any arrest pending the final autopsy. LE described the family's home as appropriate. The biological parents (BPs) denied any wrong doing. They appeared coherent and provided a consistent information about the events that led to the SC's death. ACS assessed the SS and did not document any concerns for her at the time. The SS was developmentally delayed; however, she received daily in-home therapeutic services. The family members and the shelter staff did not report any concerns for the family.

During the investigation, ACS held a child safety conference (CSC) to protect the SS. Based on the BM's past ACS history of having five children removed from her care, the BF had three children removed from his care, the reported concerns of the BPs' drug use by service providers, the family's neighbors and the pediatrician, and the BM's past suicidal ideations, the CSC recommended that the SS be placed with her MGM. The CSC also recommended PPRS services for the family. Consequently, ACS filed an Article 10 Abuse/Neglect Petition in Queens Family Court. The BPs were the respondents in the petition. Queens Family Court granted a remand for the SS and she was placed in the kinship home of the MGM under the auspice of Lutheran Social Services. A full stay away OOP was granted for the SS against the BPs. The BPs were allowed supervised visits by the FCA. The MGM supervised the BPs' visits with the SC.

On 9/14/18, ACS substantiated the allegation DOA/FATL of the SC by the SM, and the allegation IG of the SC by the BPs. Although ACS substantiated the allegation DOA/FATL of the SC by the SM, ACS failed to provide the basis to support the decision. ACS only documented the SC was in the SM's care when he passed away. Also, ACS obtained information which indicated the SM contacted the father hours before she called 911. She notified the BF of the SC's condition and he too did not call 911. The SC had a medical condition which the BPs were aware of but they did not

address the SC's condition with the pediatrician. The pediatrician confirmed the BPs missed appointments for the SC. Despite obtaining these relevant information, ACS failed to add the allegation LMC to the report and address it with the family during the investigation.

ACS referred the BPs for PPRS services. The SM completed intake on 9/10/18. The BPs tested negative for drugs/alcohol. The SS remained in the foster home of the MGM. She was adjusting well in the care of the MGM. ACS observed an adequate amount food and provisions for the SS in the home. The home was a hazard free. There were no concerns for the SS.

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?** No

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:
The level of casework activity did not commensurate with the case circumstance.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-Hour Fatality Report was not completed by ACS within the required timeframe in receipt of the 8/5/18 SCR reported allegations.
Legal Reference:	CPS Program Manual, Chapter 6, K-1

Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-Hour Safety Assessment was not approved by ACS within the required timeframe in receipt of the 8/5/18 SCR reported allegations.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	ACS had not completed or adequately assessed the SS within the required timeframe of receipt of the SCR report. On 8/6/18, ACS initially assessed the SS; however, ACS had not documented assessments of the SS thereafter.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	Neither the 30-Day Fatality Report nor the corresponding safety assessment were completed within the required timeframe of the receipt of the SCR report.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Failure to enter an incident date for substantiated allegations
Summary:	ACS did not adhere to the 5/15/17 ADM requirement for LDSS to enter the Date/Time of Incident or an approximation in the "Allegation" data field in CONNECTIONS for all children.
Legal Reference:	17-OCFS-ADM-03
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Adequacy of Risk Assessment Profile (RAP)

Summary:	The Risk Assessment Profile contained inaccurate responses regarding the family's housing, the SM's demonstration of appropriate developmental expectations of all children and elevated risk element concerning newborn with positive toxicology results.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Appropriateness of allegation determination
Summary:	Although ACS substantiated the allegation DOA/FATL of the SC by the SM, ACS failed to provide the basis to support the decision.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS failed to add the allegation LMC to the report. The SM contacted the BF hours before she called 911. The BF was aware but did not call 911. The BPs did not address the SC's medical condition with the Dr. The Dr. stated the BPs missed appointments
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/05/2018 **Time of Death:** 02:55 PM

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

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 01:50 PM
Did EMS 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

At time of incident supervisor was:

☒ Drug Impaired
☐ Alcohol Impaired
☐ Distracted
☐ Impaired by disability
☐ Absent
☒ Asleep
☐ Impaired by illness
☐ Other:

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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

On 8/5/18, LE visited the family's unit and stated there was a crib in the home which contained a rocker and other items. The SS did not have any marks or bruises. The BPs did not appear to be under the influence or intoxicated. LE deemed the home a crime scene. LE stated the SC was found face down in the bed. LE reported the SC appeared well fed.

The ER Dr. stated the SC arrived at the hospital in cardiac arrest. The ER staff made efforts to revive the SC to no avail. The SC did not have any marks or bruises on his body.

On 8/5/18, the shelter staff stated the SM did not exhibit any unusual behavior when she alerted staff about the SC's condition. The staff had CPR training and performed CPR on the SC. The staff stated weekly room checks were conducted and there were no concerns for the SC and SS. The staff recalled on 8/1/18 having had concerns that the BPs were under the influence. The staff addressed the observation and the BF responded; he suffered a fall at work and was prescribed medication. The staff stated that safe sleep was discussed with the family at every room check. The staff did not observe any items in the SC's crib during room visits.

On 8/6/18, ACS visited the family at the MGM's home. The SM provided an account of the events that led to the SC's death which was consistent with the information that was already known. The SM stated the SS was asleep in the same bed with the SM and her brother when the incident occurred. She reported that the SC vomited after feeding since birth and she informed the pediatrician. The pediatrician advised the SM to monitor the SC and scheduled an appointment for the SC for 8/7/18. There was a crib in the home for the SC but the SM did not put him in the crib. The case notes did not reflect ACS asked the SM why she did not place the SC to sleep in his crib.

The BF stated at about 11:25AM, he received a call from the SM notifying him of the SC's condition. The BF left work and arrived at the hospital after 2:00PM and was told the SC had passed. The BF denied the SC was ill prior to his death.

ACS observed the SS to be free of marks and bruises. She was developmentally delayed; however, she received daily in-home therapeutic services.

The MGM described the BPs as caring parents. She was unaware of substance use, DV or mental health issue of the BPs. ACS assessed the MGM's home. There were no safety concerns noted.

On 8/6/18, the ME stated due to lividity around the nose and the mouth; the SC was placed to sleep face down.

On 8/7/18, the pediatrician said the SC was seen twice and he appeared to be well. The BPs missed scheduled appointments for the children. The Dr. reported concerns about the BPs' appearance during visits as they both appeared thin. The Dr. stated the BPs denied substance use.

On 8/7/18, ACS held a child safety conference (CSC). The CSC recommended that the SS be placed with her MGM. The CSC also recommended mental health evaluation for the SM, bereavement counseling for the BPs, parenting skills, drug/alcohol testing and CASAC for the BPs, anger management for the SM, and EI services for the SS.

On 8/8/18, ACS filed an Article 10 Neglect Petition in QFC. The QFC granted ACS' request for a remand of the SC to the kinship care of the MGM. A full stay away OOP was granted for the SS. The BPs were allowed supervised visits. ACS informed MGM of the court's decision. The MGM confirmed her ability to enforce the OOP.

On 8/9/18, the SS was examined and medically cleared by ACS Nurse.

On 8/16/18, the ME stated the final autopsy report was pending the results further tests. The ME stated the SC appeared to be in good health and had a good weight and size.

On 9/14/18, ACS substantiated the allegation of the report against the BPs.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: 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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047612 - Deceased Child, Male, 2 Mons	048526 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
047612 - Deceased Child, Male, 2 Mons	047615 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated

047612 - Deceased Child, Male, 2 Mons	047615 - Mother, Female, 36 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐

Fatality Safety Assessment Activities

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

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious	☒	☐	☐	☐

harm, were the safety interventions, including parent/caretaker actions adequate?				

Fatality Risk Assessment / Risk Assessment Profile

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

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
ACS held a child safety conference (CSC) to protect the SS. The CSC recommended that the SS be placed with her MGM. On 8/8/18, ACS filed an Article 10 Abuse/Neglect Petition in Queens Family Court (QFC). The QFC granted a remand for the SS. The SS was placed in the kinship home of the MGM under the supervision of Lutheran Social Services.

Legal Activity Related to the Fatality

Was there legal activity as a result of 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:**
08/08/2018	There was not a fact finding	There was not a disposition
Respondent:	047615 Mother Female 36 Year(s)	

Comments:	ACS filed an Article 10 Abuse/Neglect Petition in Queens Family Court (QFC). Both parents were the respondents in the petition. The QFC granted a remand for the SS. The SS was placed in the kinship home of the MGM under the supervision of Lutheran Social Services.

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	☐	☐	☐	☐	☐	☒	☐

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)	Allegation Outcome	Compliance Issue(s)
02/07/2016	Sibling, Female, 5 Months	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Sibling, Female, 5 Months	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 5 Months	Father, Male, 35 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 5 Months	Father, Male, 35 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 2/7/16 SCR report alleged, the home was in deplorable living conditions. There was garbage on the floors, mold on the counters, the floors were filthy, the home had a fungus odor. The parents were aware of the conditions of the home and failed to take appropriate action. The SF sold marijuana and cocaine from the home in the presence of the 2-month-old SS. The SM was aware that the SF sold drugs from the home and allowed it to occur.

Report Determination: Unfounded **Date of Determination:** 03/30/2016

Basis for Determination:
The allegations of IFCS and IG against the SM and BF for the SS were unsubstantiated due to lack of evidence to support the allegations. During the CPS investigation, ACS did not observe the home to be in deplorable conditions. There was no evidence to suggest the BF sold drugs from the home or that the SM and BF were using drugs. The SM and BF submitted to a random drug test that revealed negative results for drugs and alcohol. ACS did not observe the parents to be under the influence during ACS' announced and unannounced HVs. ACS observed the SS to be well cared for by the parents. There was adequate food, provisions and clothing for the SS as well as a crib, high chair, stroller and toys.

OCFS Review Results:
Based on the documentation, ACS' decision to unsubstantiate the allegations of the report was appropriate. The BPs submitted to a random drug test that revealed negative results for drugs and alcohol. During announced and unannounced home visits, ACS did not observe the BPs to be under the influence. ACS deemed the SS safe and well cared for by the BPs.

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

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

The family has CPS history dating back to 2003 with repeated allegations of IG, B/S, PD/AM and LMC. The SM was known in two reports and the SF was known in one report.

On 8/27/03, the SCR registered a report that alleged B/S, IG and LMC of the then 11-month-old and one-year-old SS by the SM. On 8/23/03, the one-year-old SS sustained burns, however, the SM did not seek medical attention for the SS until 8/27/03. The SM did not know how the SS sustained the burns. The SM gave conflicting information about the incident. There was suspicion the injury was inflicted by the SM. The role of the two SS' father was unknown. On 10/28/03, ACS substantiated the allegation of B/S for the SS by the SM and the SC's father as they were aware the SS sustained burns and failed to seek medical attention. Both SS were removed and temporarily placed with a relative. The two SS were later paroled to their father.

On 12/5/08, the SCR received allegations of PD/AM of SS by the SM and SF. The SM gave birth to the then one-day-old adopted SS. The SM tested positive for marijuana and the SS was negative. The SM denied using any type of drugs. The BF submitted to a random drug test and tested positive for marijuana. The SF admitted to smoking marijuana a month prior to the birth of the SS. On 1/30/09, ACS substantiated the allegation of PD/AM for the SS by the SM and SF.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

On 10/22/05, the service stage was opened for PPRS and court paroled the two SS to their father with court ordered supervision (COS). The SM had weekly supervised visitation at a relative's home. The SM and the father of the two SS completed parenting, anger management and DV training. However, the SM failed to complete the mandated MH evaluation at PPRS-PRFI. On 4/27/06, the service case was closed as the COS had ended.

On 12/15/08, the service was opened as a result of the Article 10 Neglect Petition ACS filed on 12/12/08. The SM and SF were non-compliant with random drug screening, relapse prevention, parenting or DV counseling and Family Court remanded the three SS to kinship foster care.

Foster Care Placement History

A total of five children have been removed from the custody and care of the SM. Of the five children, two of the SM's children were released to their father in 2006 and three of the SM and SF's children were adopted in 2013.

On 12/12/08, ACS filed on Art 10 Neglect Petition for the three SS against the SM and SF. The SM and SF were non compliant with random screening, relapse prevention, parenting and DV counseling and monitoring.

On 3/14/10, the three SS were remanded to kinship FC with the MA under the auspices of Episcopal Social Services foster care agency. The SM and SF were non-compliant with random screening, relapse prevention, parenting and DV counseling and monitoring. On 7/6/11, the goals of the three SS PPG's was changed to adoption. The three SS were adopted and the FSS stage was closed on 2/1/13.

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