Child Fatality Report

Report Identification Number: NY-19-117

Prepared by: New York City Regional Office

Issue Date: Apr 02, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 10/28/2019
Initial Date OCFS Notified: 10/28/2019

Presenting Information

Two reports were registered with the SCR regarding the death of the SC. The reports stated that on 10/27/19 at approximately 11:45 P.M, the father placed the 2-month-old SC to sleep in her crib after feeding and burping the SC. The mother arrived from work at 4:30 A.M. and checked the SC at 4:45 A.M. The mother found the SC unresponsive with a blanket over her mouth and milk on her face. The report stated there were no items in the SC's crib. The mother called 911 at 4:48 A.M. and EMS transported the SC to Coney Island Hospital where she was pronounced dead at 5:45 A.M. The report also stated the SC was an otherwise healthy child, and the parents had no explanation for the SC's death.

Executive Summary

The SC was two-months old when she died on 10/28/19. The ME's verbal report noted the SC's death was due to Sudden Unexplained Infant Death and the manner of death was Natural.

The SC resided with his parents, MGM, 3 siblings, 2 MAs, and a MC. The father of the older twin siblings was active in his children's life and saw them frequently.

The parents were known to ACS and the SCR in one unfounded investigation.

On 10/28/19, the SCR registered two reports regarding the death of the SC with allegations of DOA/FATL, LMC, and IG of the SC by the parents.

ACS assessed the children in the household to be safe in the care of their respective parents. ACS conducted body checks for the children throughout the investigation and did not observe any suspicious marks or bruises. ACS made relevant collateral contacts with the NYPD, the ME and medical staff and none had any concern of abuse or maltreatment of the SC. The NYPD found no criminality involved in the SC's death.

ACS held Child Safety Conferences (CSC) and determined there was no need for court intervention as they assessed there were no safety concerns for the surviving children. ACS offered the family PPRS which they initially accepted, but shortly thereafter they declined.

ACS initiated the investigation timely. However, the overall investigation was not thorough as serious concerns regarding domestic violence (DV) and suspicion of drug distribution were not fully explored. During the current investigation it was revealed that although the parents denied any DV between them, the background check reflected two expired OOP. Also, it was reported there was the suspicion of drug sales from the home and banging on the walls coming from the family's home.

ACS completed all safety assessments; however, it appeared there was no in-depth assessment regarding domestic violence (DV) or drug involvement. The parents reported there was no DV in their relationship, but a background check noted there were 2 expired OOPs. A neighbor reported a suspicion of drug distribution from the home; which the family denied. The father only admitted that he smoked marijuana outside the home. ACS completed all safety assessments and the Risk Assessment Profile (RAP).

On 11/25/19, the SCR registered a report with allegations of EdN and IG of the twins by the mother. This report was unfounded on 1/17/20, however, the determination was based on actions takn by the parents after the report was made rather than the information that occasioned the making of the report.

On 2/28/20, ACS unsubstantiated the DOA/FATL allegation against the parents based on the ME's verbal report which listed the manner of death as natural. ACS determined the parents were not responsible for the death of the SC and that there was no credible evidence to substantiate the allegations of LMC or IG.

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? Yes

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

Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	ACS did not use the information gathered during the investigation to respond to the questions in the RAP and/or did not explore information relevant to the questions in the RAP.
Legal Reference:	18 NYCRR 432.2(d)

Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a 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 documentation of the progress notes were not clear and concise and did not properly respond to the questions listed in the templates. Additionally, several progress notes were entered over 30 days late.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a 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: 10/28/2019 **Time of Death:** 05:45 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 04:48 AM
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: Not impaired.

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	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)

Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

LDSS Response

ACS interviewed staff from the ER who reviewed the SC's medical record. According to the mother's account, the father had placed the SC to sleep in the crib at 11:45 P.M. and when she arrived from work, she thought the SC was asleep. The mother reported at about 4:45 A.M. she checked the baby camera on her phone and noticed the SC was not moving. The mother went to check the SC and gave the SC a kiss, she then noticed the SC was cold and unresponsive. The record reflected the mother called 911 at 4:48 A.M. EMS administered CPR and transported the SC to the hospital. The SC arrived at the hospital intubated; her skin was cool and there was no vascular activity detected. This account was consistent with the information the parents provided to ACS and the NYPD.

The NYPD and ME conducted a joint visit to the home to interview the parents. The parents provided a recording from the baby camera, which showed a timeline, the manner in which the father placed the SC to sleep and when the SC was found unresponsive. Based on the interviews and the recording, the NYPD determined there was no suspicion surrounding the SC's death.

ACS interviewed the mother who reported at the time of the SC's death she was at work. The mother said at 2:30 A.M., she took a break and checked the SC on the baby camera, and saw the father was placing the SC in the bassinet. The mother said she left work early and when she arrived at the home, she checked the SC who was lying in the bassinet, with a bottle next to her, and covered with a blanket up to her neck. The mother said she noticed the SC was unresponsive and called 911 while the father administered CPR. ACS obtained a copy of the video from the baby camera which confirmed the mother's account.

The father said on 10/26/19, he and the mother went out and returned to the home at about 2:00 A.M. The MAs cared for the children while they were out. The father said on 10/27/19, at approximately 9:00 A.M., he left the home to pick up his 6-yo son from a previous relationship. The mother left for work and the children were left in the care of the MAs as the mother left for work before he returned at 4:00 P.M.

The father said he put the SC down for a nap at about 5:00 P.M. after feeding her and changing her diaper. The SC woke up at about 7:00 P.M., he fed her, changed her diaper, and then placed her on his bed with pillows on her sides while he went to cook in the kitchen. The father said the SC was awake and the older siblings were in and out of the room playing and checking the SC. The father said at about 9:31 P.M., he told the other children to go to bed. The father said the SC fell asleep on the bed, and at about 11:20 P.M. he placed the SC to sleep in the bassinet. The father said he then went to sleep, and the mother arrived from work earlier than usual and went to check the SC. The father said he then heard her screaming out for him in a panic saying there was something wrong with the SC. The father said he took the SC from the mother and noticed the SC's head dropped back, her feet were cold, and he heard the SC wheezing. The father administered CPR and the mother called 911. The operator remained on the line as the father did CPR. The father admitted to smoking marijuana but not in the home. There was no exploration of the father's marijuana use on the day of the incident.

The 22-yo MA said she received a call from the mother at about 4:00 A.M to open the front door. The MA said after she did so, she returned to bed, and then heard the parents yelling. The MA came out of her room and learned from the mother the SC was not breathing. She then woke up the 20-yo MA who corroborated this account. The MGM reported she was not home at the time of the incident. None of the adults in the home had concerns about the parents' ability to care for the children. The children in the home had no information regarding the incident.

On 2/28/20, ACS unfounded the report.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: There was no documentation of an MDT response; however, the investigation adhered to previously approved protocols for joint investigations.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051921 - Deceased Child, Female, 2 Mons	051923 - Father, Male, 27 Year(s)	DOA / Fatality	Unsubstantiated
051921 - Deceased Child, Female, 2 Mons	051923 - Father, Male, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
051921 - Deceased Child, Female, 2 Mons	051928 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
051921 - Deceased Child, Female, 2 Mons	051928 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
051921 - Deceased Child, Female, 2 Mons	051923 - Father, Male, 27 Year(s)	Lack of Medical Care	Unsubstantiated
051921 - Deceased Child, Female, 2 Mons	051928 - Mother, Female, 27 Year(s)	Lack of Medical Care	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐

Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

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

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

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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
- ☐ 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)
07/08/2018	Sibling, Male, 8 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 8 Years	Mother, Female, 26 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 8 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Years	Mother, Female, 26 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 8 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Years	Father, Male, 25 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 8 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Years	Father, Male, 25 Years	Lack of Supervision	Unsubstantiated	

Sibling, Male, 3 Years	Mother, Female, 26 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Mother, Female, 26 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 3 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Father, Male, 25 Years	Lack of Supervision	Unsubstantiated

Report Summary:
The report alleged the parents were leaving the 3 children ages 8 (twin) and 3 yo unsupervised in the home for hours at a time on a daily basis to sell crack. The report further alleged the father was on parole and had a gun; however, it was not certain whether he maintained possession of the gun. The father listed in this report was the father of the 3 yo sibling.

The mother and father resided in separate homes, but were still in a relationship. Each resided in their parents home.

Report Determination: Unfounded | **Date of Determination:** 09/05/2018

Basis for Determination:
ACS unsubstantiated the allegations IG and LS of the 8 yo siblings against the father citing he did not have any childcare responsibilities for them. ACS unsubstantiated the allegation of the 3 yo by the father because he provided for his basic needs and had the assistance of the PGM to assist with the supervision of the 3 yo.

ACS unsubstantiated the allegations of LS and IG of the 3-and 8 yo siblings by the mother based on the information provided by collaterals who reported the mother did not leave the siblings unsupervised, this included the MGM who assisted the mother with caring for the siblings.

OCFS Review Results:
ACS did not complete a thorough investigation as the documentation of the casework activity was no focused on assessing the parents' ability to care for the children. The documentation reflected there was not a detailed review of the family's CPS history, relevant collateral contacts were not made, interviews were not sequential or based on the case circumstances, all required NOEs were not issued, progress notes reflected discrepancies that were not addressed, and supervisory directives were not completed. The person list was not updated regarding family members who resided in each of the parents' homes.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The casework activity was not focused on assessing the parents' ability to care for the children; there was not a detailed review of the family's CPS history; relevant collateral contacts were not made, interviews were not sequential or based on the case circumstances, all required NOEs were not issued,discrepanies were not addressed and the persons list was not updated persons in the home.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

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.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
Relevant collateral contacts were not made and for those that were made information was not fully explored.

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

Action:

ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a 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 on the safety assessment was not consistent with case circumstances and did not adequately reflect case circumstances.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a 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' investigation revealed the twins had not seen a pediatrician since 2016, and had attendance problems at school; which presented credible evidence to substantiate the allegation of IG and/or explore allegation of LMC or LS.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a 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 mother had no CPS history for this period. However, the father was known as the subject of a report involving his child from a former relationship.

On 10/22/14, the SCR registered a report with allegations of LMC and IG of the father's then 9-month-old child and the child's mother. The report alleged the father sold cocaine from the home and would physically assault the child's mother in his presence. It also noted that the parents smoked marijuana in the home and left it accessible to the SC.

On 12/16/14, the report was indicated against the parents. ACS substantiated the allegation of IG against the father based on DV. ACS cited the father minimized his actions and there were 5 domestic violence reports (DIR) filed with the NYPD.

The father was known as the subject of three reports involving his children and from a previous relationship and other family members. Of the three reports two were indicated and one was unfounded. The allegation of the reports were PD/AM, LS and IG. The investigations pertained to drug use and distribution, and domestic violence (DV

Known CPS History Outside of NYS

The parents had no known CPS history outside NYS.

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