NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-020 **Prepared by: New York City Regional Office**

Issue Date: 8/23/2016

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 02/23/2016
Initial Date OCFS Notified: 02/23/2016

Presenting Information

The SCR registered a report alleging that on 2/23/16, the mother left the SC unsupervised in their apartment. There was a fire in the home and the SC died in the fire. The SC's body was discovered in the home after the fire was extinguished. The mother's whereabouts were unknown. The report noted that the mother was not cooperative as she indicated there was a babysitter, but refused to provide the person's name.

Executive Summary

The 2-year-old SC died in a house fire on 2/23/16. The autopsy report listed the cause of death as smoke inhalation and the manner of death accidental. The SC sustained 3rd and 4th degree burns to her extremities and 3rd degree burns over the rest of her body.

At the time of death, the mother was a subject of an open ACS investigation dated 2/15/16. Therefore, on 2/18/16, ACS visited the family's home and found no concerns with the care the mother provided for the SC. ACS assessed the SC was safe in the mother's care and there were no safety hazards in the home.

On 2/23/16, the SCR registered a report with allegations of DOA, LOS and IG of the SC by the mother. The report alleged that the SC was left unsupervised in the home when a fire ensued and the SC died as a result.

ACS' investigation revealed that the mother told the NYPD that the SC was asleep when she left her home at about 12:00 A.M. on 2/23/16. The mother indicated that she went to meet a friend, but had arranged for a babysitter to come to the home to care for the SC. The NYPD provided the name of the alleged babysitter who ACS interviewed, but the babysitter did not corroborate the mother's account. The alleged friend the mother met on the day of the incident was not contacted.

According to the records from NYPD and FDNY, the fire started at approximately 6:50 A.M on 2/23/16. The mother arrived to the case address at 9:30 A.M. The FDNY found the SC in her bedroom lying under a toddler bed. The SC was pronounced dead at the scene at 10:36 A.M. and the body was transported to the morgue.

ACS visited the local precinct where the mother was taken for questioning. However, the NYPD did not allow ACS to be present or participate in their interrogation. The mother was arrested on the same day and subsequently released on bail. She was charged with Reckless Endangerment in the 2nd Degree and Endangering the Welfare of a Minor.

ACS made diligent efforts to contact the SC's parents via relatives; however, no one provided contact information and the parents did not respond to messages left with the relatives. ACS' efforts to contact the mother included contact with the ADA and the NYPD to obtain the mother's new address, but the mother did not provide this information to law enforcement.

On 4/22/16, ACS substantiated the allegations listed in the fatality report based on the the ME's report and the mother's admission to the NYPD that she left the SC in the home without adult supervision. ACS also cited that the

mother's poor judgement made the SC vulnerable as she was unable to protect herself when the fire ensued.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** 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

Explain:
N/A

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 has detail of the consultation.

Explain:
N/A

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/23/2016 **Time of Death:** 10:36 AM

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

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A

Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☒ Unknown
☐ Other

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was: Unknown if they were impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)

LDSS Response

Following the receipt of the fatality report, ACS proceeded to contact the NYPD, EMS, FDNY, ME, neighbors, friends, and family members. Despite ACS' efforts, the parents did not make themselves available to contribute to the investigation.

Initially, ACS visited the case address, but was denied access by the NYPD, as it was considered a crime scene. On 2/26/16, the home was boarded with debris on the front yard and a lock on the second door.

On 2/23/16, ACS was not allowed to speak to the BM at the local precinct. The NYPD indicated the BM admitted that she left the SC asleep at about midnight to meet a friend. The BM said she had arranged for a babysitter (BS) to care for the SC and left her apartment key under the garbage can located in the front yard of the home for the BS.

According to a neighbor, on 2/23/16, at about 9:00 A.M. she noticed the BM had arrived at the scene and was hysterical asking the police officers (POs) to allow her access to the home because the SC was in the apartment. The POs denied the BM access but called the FDNY to reassess the home; the SC was found under a toddler bed. The neighbor said the BM was screaming that her friend was supposed to be watching the SC. The neighbor also observed the MGM cursing at the BM and telling her that she was aware that she (BM) would leave the SC alone in the home.

ACS visited the MGM's home several times; however, the MGM refused to cooperate with the investigation and did not disclose the BM's location. The MGM's spouse reported that on the day of the incident he and the MGM heard sirens responding to a fire and sent the BM a text asking whether the fire was on her block or home. The spouse said that the BM's response was "no." However, the BM later said the fire was at her home. The spouse stated that he and the MGM immediately went to the home and found the home burned. The spouse indicated that he and the MGM sometimes babysat for the BM; however, he never met the SC's father.

ACS contacted the BS identified by the BM but the BS did not corroborate the BM's account. The BS alleged that her last contact with the SC was on 2/2/16. The BS shared that the BM was a good parent whom she met via social media in 2014. The BS said that shortly after they met, the BM had her care for the SC. The BS said she allowed the BM to pay her whatever she could afford. The BS said the BM traveled out of the state to transport illegal drugs and would leave the SC with her (BS) for 2 to 3 days at a time. The BS said the BM never returned to pick up the SC as scheduled. The BS stated that for about three months the BM had been working evenings as a stripper. The BS said that the BM had not paid her for caring for the SC and this caused a falling out.

The BS noted the BM did not smoke marijuana, but "smoked Hookah." There was no inquiry to determine what substance the BM smoked.

The BS stated that the BM was on social media with her stripper outfit the night before the incident; however, the picture had since been deleted from the network. The BS stated that whenever the BM worked at the club the BM would be dropped off at the home between 5:00 A.M. and 9:00 A.M. the next day. The BS stated that the BM sometimes returned to the home at 2:00 P.M. and would sometimes bring males to the home.

ACS interviewed another BS, CP, the SC's pediatrician, and daycare and there were no concerns about the BM's ability to care for the SC. The BM took the SC to all her medical appointments.

The EMS liaison indicated they received notification of the 911 call at 6:55 A.M. and arrived at the case address at 7:02 A.M. The SC had expired; therefore, she was not transported to the hospital

On 3/24/16, ACS contacted the ADA who confirmed the BM's criminal charges remained the same.

On 4/22/16, 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: 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

025881 - Deceased Child, Female, 2 Yrs	025882 - Mother, Female, 20 Year(s)	DOA / Fatality	Substantiated
025881 - Deceased Child, Female, 2 Yrs	025882 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
025881 - Deceased Child, Female, 2 Yrs	025882 - Mother, Female, 20 Year(s)	Lack of Supervision	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 fire began in the apartment and ACS had no access to the home after 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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
02/23/2016	Mother	Pending	Pending
Comments:	NYPD's investigation revealed that the mother left the child unsupervised. The mother was arrested on 2/23/16 and made bail.		

Criminal Charge: Reckless endangerment **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
02/23/2016	Mother	Pending	Pending
Comments:	NYPD's investigation revealed that the mother left the child unsupervised. The mother was arrested on 2/23/16 and made bail.		

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☒	☐	☐	☐	☐
Mental health services	☐	☐	☐	☒	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☒	☐	☐	☐	☐	☐	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐

Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

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:
No children in the household.

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

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? N/A
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)
02/15/2016	9941 - Deceased Child, Female, 2 Years	8802 - Mother, Female, 21 Years	Lack of Supervision	Indicated	Yes
	9941 - Deceased Child, Female, 2 Years	8802 - Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	9941 - Deceased Child, Female, 2 Years	8802 - Mother, Female, 21 Years	Inadequate Guardianship	Indicated	
	9941 - Deceased Child,	8802 - Mother,	Lacerations / Bruises /	Unfounded	

Female, 2 Years	Female, 21 Years	Welts	
9941 - Deceased Child, Female, 2 Years	8802 - Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unfounded

Report Summary:
The report alleged that the mother would forcefully hit and pinch the SC out of anger inflicting red marks on the SC's body. It also alleged the the SC was ignored, not fed properly and left unattended in the home for long periods of time while the mother engaged in prostitution in the home. It was also noted that the mother worked evenings and left the SC with various strangers. Further, the report alleged that the SC was exposed to mother abusing marijuana and alcohol to intoxication along with several other unrelated adults who frequented the home daily.

Determination: Indicated **Date of Determination:** 03/04/2016

Basis for Determination:
ACS substantiated the allegations of LOS and IG of the SC by the mother citing that the mother failed to provide supervision for the SC. The report noted that on 2/23/16, the SC was left alone in the apartment and a fire ensued which caused the SC death. The mother arrived at the scene two hours after the fired was put out.

ACS unsubstantiatiated the allegations of PD/AM, LBW and I/F/C/S. ACS noted that the mother refused to submit to a drug screening and denied drug use. The home appeared appropriate with adequate provisions for the SC. In addition, neither the Specialist nor the daycare provider observed marks or bruises on the SC.

OCFS Review Results:
NYCRO's review of ACS' investigation found that both the SC and the mother were seen on 2/18/16. There were no concerns about the SC or the home. However, on 2/23/16, the mother left the SC unattended in the home for an unspecified amount of time. A fire ensued in the home and as result the SC died of smoke inhalation. The SC was found under her toddler bed and was pronounced at the scene. The mother was arrested and subsequently charged with endangering the welfare of a minor. The mother was released on bail and had no further contact with ACS throughout this investigation. ACS made attempts to contact the SC's father; however, he was not responsive.

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

Issue:
Failure to Provide Notice of Indication
Summary:
ACS did not issue a Notice of Indication to the father.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to provide notice of report
Summary:
ACS did not issue a Notice of Existence for the father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended,

and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The safety assessment was not properly completed. ACS selected a safety decision that noted safety factors existed; however, did not select any safety factors.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/31/2015	9871 - Deceased Child, Female, 19 Months	8805 - Mother, Female, 20 Years	Inadequate Guardianship	Unfounded	Yes
	9871 - Deceased Child, Female, 19 Months	8805 - Mother, Female, 20 Years	Lack of Medical Care	Unfounded	
	9871 - Deceased Child, Female, 19 Months	8805 - Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unfounded	
	9871 - Deceased Child, Female, 19 Months	8805 - Mother, Female, 20 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:
On 7/30/15, ACS unsubstantiated the allegations of I/F/C/S, LMC, PD/AM and IG of the subject child by the mother. ACS based their determination on the fact that the mother was meeting the SC's medical and basic needs. Visits to the home revealed the SC's living environment was appropriate with adequate provisions. In addition, the mother submitted to a drug screening and the results was negative.

Determination: Unfounded | **Date of Determination:** 07/30/2015

Basis for Determination:
On 7/30/15, ACS unsubstantiated the allegations of I/F/C/S, LOMC, PD/AM and IG of the subject child by the mother. ACS based their determination on the fact that the mother was meeting the SC's medical and basic needs. Visits to the home revealed the SC's living environment was appropriate with adequate provisions. In addition, the mother submitted to a drug screening and the results was negative.

OCFS Review Results:
NYCRO's review found that ACS noted there were no concerns about the conditions of the SC's home. ACS interviewed the PPRS' CP and the PGGF who reported no concerns pertaining to the allegations or with the level of care, the mother provided to the SC. However, the SC's babysitter indicated that the mother was often away from the SC and did not leave appropriate provisions during these times. ACS did not sufficiently explore this information. ACS documented the SC's immunization were current; but did not contact the pediatrician. There was no attempt to contact the SC's father. The case remained opened with PPRS services.

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

Issue:

Failure to provide notice of report

Summary:

ACS did not issue a Notice of the report to the father.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

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

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

The information provided by the SC's babysitter was not sufficiently explored, the pediatrician was not contacted for an interview nor was the SC's father.

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 and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Required data and official documents

Summary:

The information pertaining to the SC's father was not entered in CONNECTIONS' person list.

Legal Reference:

428.3(b)(2)(i)

Action:

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

ACS copied the same safety factors listed in the safety assessments from the previous investigation, but again did not explain how the safety factors were impacting the mother ability to care for the SC.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

ACS copied the safety factors listed on the 7-Day Safety Assessment and the Safety Assessments from the previous investigation; however, did not explain how the safety factors impacted the mother's ability to care for the SC.

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(b)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/27/2015	9932 - Deceased Child, Female, 16 Months	8807 - Mother, Female, 20 Years	Inadequate Guardianship	Unfounded	Yes
	9932 - Deceased Child, Female, 16 Months	8807 - Mother, Female, 20 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:

The SCR report alleged that the mother's home was unclean and hazardous for the SC. The report noted that there were holes in the wall and ceilings and the stairs were broken. The report also noted that there was water dripping from the bathroom ceiling, and the floors were filthy with dirt and debris strewn all over. It was further reported that there was old food in pots and pans in the refrigerator and on the stove.

Determination: Unfounded | **Date of Determination:** 04/28/2015

Basis for Determination:

ACS unsubstantiated the allegations of IG and IFCS based on the observations of the apartment, which did not reflect any of the reported safety hazards or conditions. The home was clean, the child had adequate provisions and the collateral contacts made with relatives indicated that the mother was a good parent.

OCFS Review Results:

NYCRO's review of ACS investigation found that the mother resided on the third floor of a three-story brownstone owned by the SC's PGGF. The father resided in the home with the mother and SC, but abandoned the family to start a new relationship and had another child. ACS interviewed the PGGF who reported that the father and the PGPs asked him to evict the mother, but he refused. The PGGF described the mother as a good parent and had no complaints about her behavior or her ability to care for the SC. The conditions of the home reported to the SCR were not present; the apartment was in no need of repairs and was clean during ACS' visits. The mother was referred for PPRS.

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

Issue:

Failure to provide notice of report

Summary:

ACS did not issue a Notice of Existence to the father.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

The documentation did not reflect efforts to contact the PGPs or the father. The documentation noted medical information about the SC, but it does not appear that there was a discussion with the pediatrician.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

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

Issue:

Required data and official documents

Summary:

ACS did not update the CONNECTIONS database with relevant information about the SC's father. He was not listed in the Connections person list.

Legal Reference:

428.3(b)(2)(i)

Action:

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

ACS selected safety factors noting information from the mother's history as a child, but did not link these to the impact of the mother's ability to care for the SC.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

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

Issue:

Predetermination/Assessment of Current Safety and Risk

Summary:

ACS copied the safety factors selected for the 7-Day Safety Assessment on to the Determination Safety Assessment, but again did not explain how these impacted on the mother's ability to care for the SC.

Legal Reference:

18 NYCRR 432.1(aa)

Action:

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

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

Between 2000 and 2012, the mother was listed as a SC in five reports; one was indicated.

The reports reveal that the MGM was abusive to the mother and her siblings; however, the focus of the investigation was the mother's behavior that after several years was associated with clinical issues.

The mother had multiple clinical hospitalizations; the most recent was on 12/21/09 when she was admitted to Brookdale Hospital. At the time of hospitalization, the MGM sought a voluntary placement for the mother as the mother was aggressive towards her siblings and the MGM and was truant from school. The mother was transferred to St. Vincent's Hospital on 12/24/09 when it was determined that she needed a higher level of care. ACS and St. Vincent's Hospital explored the discharge options for the mother, which included placement in an RTF or discharge home with services. The MGM withdrew her request for voluntary placement and declined any further contact from ACS.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Services Open at the Time of the Fatality

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

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

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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

Explain: OCFS is recommending that ACS Supervisory Team review with the Specialists the CONNECTIONS' Step-by-Step Guide: Training for CPS Workers (rev 3/1/07) page 204, which addresses Safety Assessments, and to review the Safety Assessments submitted for this report. Staff must be reminded that when there are no surviving siblings and/or minor children in the home, the Specialist must select "no surviving siblings" in the Investigation Conclusion window of the CONNECTIONS database at the inception of the investigation to prevent the CONNECTIONS system from generating the Safety Assessments and Risk Assessment Profile.