Child Fatality Report

Report Identification Number: NY-16-063

Prepared by: New York City Regional Office

Issue Date: May 31, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	

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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 06/26/2016
Initial Date OCFS Notified: 06/26/2016

Presenting Information

Between 6/26/16 and 6/27/16, the SCR registered two reports and received additional information concerning the death of the SC. According to the reports, at approximately 1:45 P.M., after feeding the SC, the mother laid the child face down in the crib. At about 2:30 P.M. the mother checked the SC and found the child unresponsive. The reports noted the mother called 911, and the SC was transported to Woodhull Hospital by EMS. According to the report, the mother was the sole caretaker of the SC when she (SC) was found unresponsive. It was also noted that blood from the SC's nose was found in the SC's crib.

The report indicated the SC had healing fractures to her ribs and skull. The report noted that both parents were the caretakers of the SC when she sustained the fractures. It was suspected the parents injured the SC. According to the report, the 11-month-old sibling had no role in the case.

Executive Summary

The SC was one month old when she died on 6/26/16. As of 5/30/17, the OCME OCFS has not received the autopsy report for this child.

NYCRO's case review indicated the family was placed in a family shelter operated by the NYC Department of Homeless Services. The family was under Court Ordered Supervision (COS) as a result of an Article Ten Neglect Petition filed by ACS at the Kings County Family Court (KCFC) on 3/10/16. The mother had been arrested and the sibling was placed with the Commissioner of ACS. On 4/26/16, the sibling was released with ACS supervision to the mother by the KCFC; the Coalition for Children and Families (CCF) foster care agency was also monitoring the home due to the sibling's discharge.

NYCRO's review of the Family Services Stage (FSS) for the COS prior to the SC's death, indicated ACS was not adequately monitoring activities in the home. There was no follow up to assess the parents' relationship, domestic violence concerns, the terms of the father's release, or his role in caring for the children. The records also did not reflect an assessment of the father's need for services. In addition, there were no progress notes entered from 4/30/16 through 5/11/16 that reflected ACS or the CCF was monitoring the mother's expected delivery of the SC, the plans to supervise the sibling while the mother gave birth, hospital discharge plans or the SC's needs, or the household's functioning.

On 6/10/16, the SCR registered a report for Inadequate Guardianship of the sibling by the father. The report involved concerns of domestic violence between the parents where the father physically assaulted the mother in the street while she was holding the sibling. The allegation of this report were substantiated against the father. On 6/22/16, as a result of this report, the KCFC issued a full stay away order of protection (OOP) against the father on behalf of the family.

On 6/26/16 and 6/27/16, the SCR registered two reports concerning the death of the SC. The reports listed allegations of DOA/Fatality, Fractures, Internal Injuries, and Inadequate Guardianship of the SC by the parents.

ACS responded to the SCR reports within the required time frame and appropriately assessed the safety of the surviving sibling. Based on the unknown circumstances of the SC's injuries and death, ACS had the sibling medically cleared and removed from the parents' custody. The medical clearance revealed there were no signs of abuse, neglect, or any medical concerns. The sibling was taken from Woodhull Hospital to the ACS Children's Center.

The medical staff from the hospital indicated the SC had old fractures to the left and right ribs, a hairline skull fracture and old bruising on the body. The medical staff noted that on 6/26/16 the mother arrived with the SC at the ER with EMS and the SC was pronounced dead at 3:49 P.M. The mother was distraught and did not provide the medical staff with the events leading up to the SC's death.

After the SC was pronounced dead at Woodhull Hospital, the mother was questioned by the NYPD. ACS went to the local precinct, but was not allowed to observe or participate the mother's interview with the NYPD. The detective noted there would be no arrest pending the results of the autopsy report as the death of the SC had not been deemed a homicide. The whereabouts of the father were unknown. However, the father was later arrested on 6/28/16 by the NYPD for the violation of the OOP. The mother was not held accountable for her violation of the OOP.

ACS held a Child Safety Conference (CSC) where the parents participated via telephone.

According to the father on 6/26/16, he was sleeping for most of the day and at about 2:30 P.M., he went to the bathroom and heard the mother scream. The father stated he came out of the bathroom and noticed the SC's lips were blue and she was not breathing. The father said once EMS arrived, he left the shelter because he was aware he was in violation of the OOP. The father explained he had no place to go after he was released from jail on an unrelated matter. The mother provided inconsistent accounts; initially while at the CSC, she gave a similar account to the father's ; however, she later gave a different account. Neither parent was able to provide a plausible account to explain how the SC sustained the injuries.

On 6/27/16, ACS filed an Article Ten Neglect Petition on behalf on the sibling. The sibling was remanded and placed in the custody of the Commissioner of ACS. The sibling was placed in a non-kinship home under the auspices of Edwin Gould Services' foster care agency. In November 2016, ACS identified a relative for the sibling and she was replaced in a relative kinship home.

On 1/18/17, ACS contacted the ME; however, the ME did not provide any information concerning the cause and manner of death.

On 2/17/17, ACS determined there was credible evidence to substantiate the allegations of DOA/Fatality, FX, II and IG against the parents. The report was indicated and remains open for CPS intervention.

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

Explain:
N/A

Was the decision to close the case appropriate?	N/A
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	ACS completed this safety assessment timely and selected a correct safety decision. The surviving sibling was removed from the parents' custody within the first 24 hours and remained in care. However, the selected safety factors and comments to support these did not reflect a clear understanding of the information required in selecting safety factors.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
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:	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:	This report was not approved timely and the documentation consisted of copying and pasting of progress notes without providing any assessment of the family's functioning.
Legal Reference:	CPS Program Manual, VIII, B.1, page 2
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:	Overall Completeness and Adequacy of Investigation
Summary:	After the initial contacts with relevant collaterals, ACS had significant lapses in the documentation where they did not focus on contacting the ME or the NYPD to continue to investigate the cause of the SC's death or the concerning the death of the SC or the status of the criminal investigation.

	The supervisory notes did not reflect that there was guidance relevant to the circumstances of the case.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
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:	Adequacy of services following the fatality
Summary:	The father was ordered to receive services for anger management and batterer's accountability. ACS sent an e-mail to Riker's Island to request the services for the father. However, the documentation does not reflect follow up on this e-mail even though the investigation stage has remained open.
Legal Reference:	18 NYCRR 432.2(b)(4);428.6
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:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	ACS completed and approved the Risk Assessment Profile (RAP) on 7/20/16 without gathering all relevant information to properly respond to the questions listed on this form. In addition, some questions were not properly answered and/or were not explored. The determination is overdue, therefore, ACS has not completed the determination safety assessment.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
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 24 Hour Assessment
Summary:	ACS completed this safety assessment timely and selected a correct safety decision. The surviving sibling was removed from the parents' custody within the first 24 hours. However, the selected safety factors and comments to support these did not reflect a clear understanding of the information required in selecting safety factors.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/26/2016 **Time of Death:** 03:49 PM

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? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Month(s)

LDSS Response

Following the fatality reports, ACS made contact with the NYPD, Woodhull Hospital, the ME, relatives and neighbors.

The medical staff from the hospital indicated the SC had old fractures to the left and right ribs, a hairline skull fracture and old bruising on the body.

On 6/26/16, the NYPD indicated there would be no arrest pending the results of the autopsy report.

According to the NYPD, during interviews with the mother she disclosed the father had kicked the SC's crib on 6/26/16, due to his frustrations with the SC crying. The mother also told the NYPD that in the past the father had picked up the SC and screamed in her (SC) face due to the child crying. ACS did not explore and/or document why the mother was not arrested with the father for the violation of the order of protection.

On 6/27/16, ACS held a Child Safety Conference and both parents participated via telephone. The location of the parents

was not documented.

According to the information gathered from the parents, on 6/26/16 at approximately 1:45 P.M., the mother fed the SC a bottle a of formula, burped her and changed the SC's diaper before placing the SC to sleep in her crib. The mother said she laid the SC on her (SC) stomach with her head to the side. The documentation did not reflect that the parents were aware of, or were provided any information regarding safe sleeping positions for infants.

The mother said that at about 2:30 P.M., the sibling began crying so she picked her up from the playpen. At this time, the father got out of bed and walked to the bathroom. The mother said she then went to check the SC and noticed there was drops of blood by the SC's head. The mother said she placed the sibling on the bed then picked the SC up from the crib, and noticed the SC was not breathing and her body was lifeless.

The mother said she called out for the father and immediately dialed 911 at which time the operator instructed the mother on how to administer CPR until EMS arrived at the home. The father said the SC's lips were blue and she was bleeding from her nose. The mother said once EMS arrived they continued resuscitation efforts and transported her and the children to Woodhull Hospital. The father indicated that once EMS arrived he left the home because he was in violation of the order of protection.

The mother did not provide a reason for the father's presence in the home. Neither parent was able to provide an explanation for the injuries sustained by the SC. They also made no admission of abuse of the SC.

During the CSC, the MGM disclosed there was domestic violence between the parents and that the level of violence by the father towards the mother had escalated over time. The MGM said she had witnessed the father push, kick and punch the mother in the presence of the sibling. The MGM noted the mother was fearful of the father and she (MGM) had witnessed the mother running away from the father. There was no documentation of dates for the events described by the MGM.

ACS had concerns about the mother's accounts of events for the day of the incident because on 6/29/16, the mother said the father was asleep until 2:30 P.M. and when he woke up, he asked her to "roll a blunt (marijuana)" for him and then went in the bathroom. The mother said she was rolling a blunt when she found the SC unresponsive. The mother had not provided this information during the initial interview. The father was not very cooperative during the investigation. There was no clarification as to what actually took place concerning events leading up to the SC's death.

Neighbors reported that on 6/24/16, in the evening, the father was overheard screaming at mother telling her to "shut up" and using foul language. It was noted the SC was not heard crying on this day or during the weekend. The NYPD were not called concerning this incident.

ACS later learned that in addition to the two children the parents had in common, the father had two other children from two former relationships. ACS assessed these two children were safe in the care of their mothers. ACS also learned that there was domestic violence in these two relationships and the father had no contact with these children. However, on 7/1/16, ACS filed two additional derivative abuse by the father with the Kings County Family Court on 7/1/16. These children were added to the active order of protection due to the derivative abuse.

In November 2016, ACS contacted the Riker's Island Correctional Facility to request services for the father. The notes do not specify whether the father completed any services to date.

On 1/15/17, ACS requested that Riker's Island Correctional Facility complete an evaluation for the mother. The status of these requests have not been documented. As of 2/2/17, both parents remain in jail on non-fatality charges.

On 2/17/17, ACS determined there was credible evidence to substantiate the allegations of DOA/Fatality, FX, II and IG of the child against the parents. The report was indicated and remains open for CPS intervention.

Official Manner and Cause of Death

Official Manner: Pending
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: 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
032381 - Deceased Child, Female, 1 Mons	033842 - Father, Male, 22 Year(s)	DOA / Fatality	Substantiated
032381 - Deceased Child, Female, 1 Mons	033842 - Father, Male, 22 Year(s)	Internal Injuries	Substantiated
032381 - Deceased Child, Female, 1 Mons	033841 - Mother, Female, 20 Year(s)	DOA / Fatality	Substantiated
032381 - Deceased Child, Female, 1 Mons	033841 - Mother, Female, 20 Year(s)	Internal Injuries	Substantiated
032381 - Deceased Child, Female, 1 Mons	033841 - Mother, Female, 20 Year(s)	Fractures	Substantiated
032381 - Deceased Child, Female, 1 Mons	033842 - Father, Male, 22 Year(s)	Fractures	Substantiated
032381 - Deceased Child, Female, 1 Mons	033842 - Father, Male, 22 Year(s)	Inadequate Guardianship	Substantiated
032381 - Deceased Child, Female, 1 Mons	033841 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine

All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The required documentation was completed as per protocol; however, the quality of the assessments was inadequate.

Fatality Safety Assessment Activities

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

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: N/A				

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:**
06/27/2016	Adjudicated Abused	Article 10 Remand
Respondent:	033841 Mother Female 20 Year(s)	
Comments:	The sibling was remanded due to the unexplained injuries and death of the SC.	

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	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? Yes
Explain:
The sibling was removed from the home and placed in foster care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The parents did not have any 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? 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)	Status/Outcome	Compliance Issue(s)
06/10/2016	13701 - Sibling, Female, 11 Months	13704 - Father, Male, 21 Years	Inadequate Guardianship	Indicated	Yes

Report Summary:

The SCR registered a report alleging the father pushed the mother into the street while she was holding the 11-month-old sibling. The report stated the mother sustained a hematoma to the back of her head and scratches to her left arm. According to ACS' investigation, EMS staff indicated that when they arrived at the scene, they witnessed the parents arguing and the mother was surrounded by a group of people who were protecting her from the father. The witnesses informed EMS the father pushed the mother into traffic while she held the sibling.

ACS obtained the recordings of the 911 calls from the witnesses and proceeded to contact each witness. According to witnesses, the father was hitting, dragging, berating and pushing the mother as she attempted to get away from him. ACS returned to the KCFC to petition for COS. On 6/22/16, the KCFC ordered ACS to add the father to the original petition and issued a full stay away OOP against the father on behalf of the family. The father was allowed supervised visits at the agency three times a week. The parents lied to hospital staff, EMS and ACS by saying the mother was hit by a car. All the witnesses denied the mother was ever hit by a car. The FCLS obtained tapes of several 911 calls of the witnesses who observed the father's violent behavior. These calls were shared with all participants present at the KCFC.

On 6/26/16, the SCR registered a report concerning the death of the SC.

ACS continued with this investigation and learned the SC sustained serious injuries. ACS also learned the father never

left the home; therefore, the mother had not made any effort to enforce the OOP. ACS returned to KCFC and petitioned for the remand of the sibling. The remand was granted and the sibling reentered the foster care system.

As of 1/30/17, the fatality investigation remains open as the ME has not issued a cause and manner of death. Since the ME has not deemed the SC's death as a homicide, no one has been arrested in CONNECTION to the SC's death. However, after being interviewed by the NYPD, the mother disclosed several incidents where the father behaved violently towards the SC in her (mother) presence. There was no indication the mother intervened to protect the SC. Despite the information gathered, ACS did not hold the mother accountable for her failure to enforce the OOP.

The father was arrested for the violation of the OOP.

Determination: Indicated	**Date of Determination:** 08/09/2016

Basis for Determination:
ACS substantiated the allegation of Inadequate Guardianship of the sibling by the father because there were multiple witnesses to the incident. However, based on the mother's actions and/or lack thereof, ACS should have added her as a subject for Inadequate Guardianship to this report and substantiate the allegation.

OCFS Review Results:
NYCRO's review revealed ACS initiated the investigation timely and made relevant collateral contacts to verify the validity of the information registered by the SCR. ACS obtained concrete evidence concerning the father's violent behavior. However, ACS did not take into consideration the family's child welfare history, parent's criminal history and the mother's poor judgment. The mother 's attempt recent attempt to smuggle drugs into the Riker's Island Correctional facility by hiding the drugs in the sibling's diaper.

ACS decision to file an Article Ten Neglect Petition in response to the domestic violence was appropriate. However, based on the mother's blunt denial of the allegations despite the number of witnesses, ACS had overwhelming documentation to support a petition for a remand of the children as opposed to a continuation of the COS petition. It was not clear whether the mother's actions to excuse the father was out of fear or some type of loyalty. In addition, the mother was previously referred for a mental health evaluation but the case record did not reflect the evaluation had been completed. These issues were imperative to assess whether the mother would have the ability to enforce the order of protection. It was evident, by the death of the SC, the mother's judgement was poor when it related to her ability to care and protect the children. as the father never left the home.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The safety assessment was not approved within the required 7 day period. ACS selected a safety decision noting there was immediate and impending danger of serious harm to the children. However, did not list any safety factors to support their decision.

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 selected an appropriate safety decision indicating there was immediate and impending danger of serious harm to the children However, did not support the selected safety factors selected. The RAP was completed and approved prematurely as information related to some of the questions were not gathered. Also, the comments provided to support the responses of some questions were not relevant.

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.

Issue:

Failure to Provide Notice of Indication

Summary:

The CONNECTIONS event list did not reflect that a NOI was issued to the parents.

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:

The CONNECTIONS event list did not reflect the NOE was issued for the parents.

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:

Appropriateness of allegation determination

Summary:

ACS substantiated the allegation of Inadequate Guardianship of the sibling by the father because there were multiple witnesses to the incident. However, based on the mother's actions and/or lack thereof, failed to add her as a subject for Inadequate Guardianship to this report and substantiate the allegation against.

Legal Reference:

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

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:

Assessment as to need for Family Court Action

Summary:

Although ACS' decision to file an Article Ten Neglect Petition in response to the domestic violence was appropriate. During this investigation, ACS had overwhelming evidence and documentation to support a petition for a remand of the children as opposed to a continuation of the COS petition.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/09/2016	12306 - Sibling, Female, 8 Months	12305 - Mother, Female, 20 Years	Inadequate Guardianship	Indicated	Yes

Report Summary:

The mother was arrested for attempting to smuggle marijuana to Riker's Island for the father. Officers found the mother hid the drugs in the sibling's diaper. The mother was 8 months pregnant with the now deceased SC. ACS went to Riker's Island where they conducted an emergency removal of the sibling as neither parent was available to care for the child.

On 3/10/16, ACS filed an Article 10 Petition of Neglect and the sibling was remanded and placed in a non-kinship home. The possible kinship resources provided by the mother were explored, but they were not cleared to care for the sibling. According to the mother, she pleaded to a misdemeanor charge and was released from jail with community services. After the BM was released, the sibling was discharged to the BM with COS on 4/26/16. The SC was born two days prior to ACS' determination, but was not added to the family composition.

Determination: Indicated | **Date of Determination:** 05/06/2016

Basis for Determination:

The allegation of IG of the sibling was substantiated against the mother. ACS noted there was credible evidence indicating the mother placed the sibling's "mental, physical, and emotional health at risk of imminent risk of harm." ACS cited the mother's actions of smuggling the drugs to Riker's Island which led to the sibling's removal.

Although the father was involved planning the smuggling of the drugs into the jail and had returned to reside with the family, ACS did not add him as a subject of the report or assess the children's safety with his presence in the home once he was released.

OCFS Review Results:

NYCRO's review found the assessments and crucial decisions concerning this investigation was poorly documented.

After the removal of the sibling, who was remanded to the care and custody of the Commissioner of ACS, the documentation noted a settlement conference was held on an unspecified date between the CPM and the FCLS where the sibling would be released to the mother with COS. In addition, it was noted the mother agreed to re-enter foster care with her children. Prior to this note, there was no mention/summary of the mother's foster care history to explain how she left the system and ended up homeless. The documentation did not reflect what steps the mother would need to take to re-enter foster care.

The father was released from jail on 4/25/16 and returned to live at the shelter with the family. He was seen by the Specialist caring for the sibling in the home on 5/5/16 while the mother was at the hospital giving birth to the SC. This was a violation of the order of protection that was issued as a result of the Article 10 Petition on 3/10/16. Although ACS repeatedly noted that the DV between the parents was a safety factor, there was no safety plan and/or conference to

address this issue. ACS completed the investigation on 5/6/16 without consulting FCLS of the violation of the order of protection. It was not clear how ACS determined the children would be safe in the mother's care.

The documentation to support the safety factors was convoluted and did not reflect a clear understanding of the family's circumstances. It also did not appear to focus on the parents' actions or lack thereof concerning their ability to care for the children.

In the determination safety assessment ACS selected a safety decision which noted there were safety factors that placed the children in immediate or impending danger of serious harm. However, ACS returned the sibling to the mother and did not fully assess her ability to care for the SC. There was no safety plan added to the safety assessment. ACS repeatedly noted that the mother accepted PPRS, had agreed to complete parenting skills and a mental health evaluation. There was no understanding of the development of a safety plan prior to allowing the mother remain in the home with the children as ACS had also learned that both parents had violated the order of protection.

ACS inappropriately selected a closure reason noting "CPS not required" even though the family was under COS. ACS did not add the father as a subject of this report although he was the person who requested that the mother smuggle the drugs to the jail.

ACS also changed the stage name to the father's name and proceeded to open a FSS under his name, but he was not the subject of the report.

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

Issue:
Failure to provide notice of report
Summary:
The CONNX event list does not reflect that the NOE was issued for the father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this investigation 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 Indication
Summary:
The CONNX event list does not reflect that the NOI was issued to the parents.
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:
Timely/Adequate Seven Day Assessment
Summary:
The 7-Day Safety Assessment was not approved in a timely manner. Additionally, the assessment did not accurately capture the case circumstances.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this investigation 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:
In the determination safety assessment ACS selected a safety decision which noted there were safety factors that placed the children in immediate or impending danger of serious harm. However, ACS returned the sibling to the mother and did not fully assess her ability to care for the SC. There was no safety plan added to the safety assessment. ACS repeatedly noted that the mother accepted PPRS, had agreed to complete parenting skills and a mental health evaluation. There was no understanding of the development of a safety plan prior to allowing the mother remain in the home with the children as ACS had also learned that both parents had violated the order of protection.
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.

Issue:
Adequacy of Progress Notes
Summary:
The progress notes were convoluted and did not reflect the process in which ACS made crucial decisions. Especially when returning the sibling to the mother. There is no clear progress notes concerning the mother's agrrement
Legal Reference:
18 NYCRR 428.5
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)
09/05/2015	12291 - Sibling, Female, 2 Months	12292 - Father, Male, 21 Years	Inadequate Guardianship	Unfounded	Yes

Report Summary:
The report noted the parents engaged in a physical altercation in the presence of the two month old sibling. It was alleged the BM ran out of the home wrapped in a towel after the BF attempted to sexually assault her. The report noted the BM arrived at the hospital where she slept for an hour. The BM did not know where she was and left the hospital abruptly. There was no indication of the sibling's whereabouts. There was concerns about the BM's mental stability.

The BM gave conflicting accounts of the incident and her alleged attacker to the hospital SW. However, the BM told ACS she was attacked at her friend's home by an acquaintance of her friend and that the SC was with the BF.

Determination: Unfounded | **Date of Determination:** 10/02/2015

Basis for Determination:
ACS UNSUB the allegation of IG of the sibling by the BF citing there was no DIR registered for the reported incident and neither the BM nor the SC had marks or bruises. ACS noted that the sibling was too young to provide an account and the parents appeared to meeting the child's needs.

The narrative did not consider the information provided by the ACS' IC who indicated there was a DIR dated 3/16/15 where the BM was listed as a victim and the BF as the suspect . The incident involved a verbal dispute about breaking up and the BF swung a belt at the BM, but missed.

OCFS Review Results:
NYCRO found this was not a thorough investigation and could have been merged with the 8/5/15 report. ACS did not make relevant collateral contacts in this case such as the NYPD, the friend or paternal relatives to corroborate the parents' accounts. ACS did not consider the 3/16/16 DIR to explore the allegations noted in this report and properly assess the safety of the sibling. The determination was premature and based mostly on the parents account of the sibling's alleged whereabouts at the time of the incident.

Although ACS noted there was no evidence to corroborate the reported incident occurred, it was noted as a safety factor in the determination safety assessment.

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

Issue:
Appropriateness of allegation determination
Summary:
The determination was based mostly on the parents' account of the sibling's alleged whereabouts at the time of the incident and their denial that the incident occurred.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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:
Face-to-Face Interview (Subject/Family)
Summary:
The father who was the subject of this report was not interviewed face to face.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
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:
ACS did not conduct a thorough investigation of the allegations reported. Information gathered concerning DV was not utilized to further explore the allegations of the report and/or properly assess the safety and/or future risk of the sibling in the care of the parents. The investigation was completed in 28 days.
Legal Reference:

SSL 424(6); 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 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:

ACS did not make relevant collateral contacts with the NYPD, the mother's friend or paternal relatives to properly investigate the parents' account.

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:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

ACS noted one safety factor concerning the mother's drug use; however, she was not added as a subject to this report and the impact her drug use had on her ability to care for the sibling was not specified.

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.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

ACS listed the BM's drug use and domestic violence. However, the comments contradicted the safety decision and safety factors selected. In addition, the safety assessment did not reflect a safety plan.

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)
08/05/2015	11923 - Sibling, Female, 1 Months	11921 - Mother, Female, 20 Years	Inadequate Guardianship	Unfounded	Yes
	11923 - Sibling, Female, 1 Months	11922 - Father, Male, 21 Years	Inadequate Guardianship	Unfounded	

11923 - Sibling, Female, 1 Months	11921 - Mother, Female, 20 Years	Sexual Abuse	Unfounded
11923 - Sibling, Female, 1 Months	11922 - Father, Male, 21 Years	Sexual Abuse	Unfounded
11923 - Sibling, Female, 1 Months	11921 - Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Indicated
11923 - Sibling, Female, 1 Months	11922 - Father, Male, 21 Years	Parents Drug / Alcohol Misuse	Unfounded

Report Summary:
The report alleged the BF was touching the sibling in an inappropriate sexual manner and the BM failed to intervene. It was also alleged that the BM was smoking marijuana and exposing the sibling to the smoke. The BM allegedly dropped the sibling due to being impaired by her use of marijuana. The report also alleged that the parents engaged in DV incidents and criminal activities in the presence of the sibling. The report noted that the BF was drunk when assaulting and robbing others.

The BM was pregnant and the family was residing in a family shelter since 7/20/15.

Determination: Indicated **Date of Determination:** 10/02/2015

Basis for Determination:
The allegations against the parents were UNSUB with the exception of the PD/AM of the SC by the BM. ACS' narrative to SUB this allegation against the BM was based on the BM testing positive and admitting to smoking marijuana. ACS noted the BF denied using alcohol and appeared coherent during a telephone interview. ACS did not specify how the BM's drug use impacted her ability to care for the SC.

Concerning the allegations of IG and SA, ACS noted there was no evidence the BM dropped the SC or DIRs indicating there was DV in the home. ACS noted that the SC's basic needs appeared to be met. Also, the CAC found no indication of sexual abuse.

OCFS Review Results:
NYCRO's review revealed that this investigation was not thorough as there was insufficient collateral contacts to investigate the allegations of the report. The proper notifications were not issued for the parents. There was minimal effort to engage the BF during the investigation. The documentation did not include details of events. ACS attempted to file an Article 10 for COS, but was deferred by FCLS as they did not have sufficient information to file. All supervisory directives were not completed prior to the approval of the determination. The information listed in the safety assessments and RAP was not consistent with that gathered during the investigation.

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

Issue:
Failure to provide notice of report

Summary:
The CONNX event list reflect that the NOE was not issued for the father.

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

Action:
ACS must meet with the staff involved in this investigation 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 Indication

Summary:
The CONNX event list reflects that the NOI was not issued for the parents.
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:
Contact/Information From Reporting/Collateral Source
Summary:
There was no contact with the shelter staff or the SC's pediatrician. The Specialist was directed to contact the mother of the father's other child, but ACS attempted to get the contact information from the mother and did not attempt to ask the father and/or paternal relatives.
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:
Face-to-Face Interview (Subject/Family)
Summary:
There was insufficient efforts to interview the father face to face even though he was a subject of this report. ACS spoke to the father once via telephone and noted he participated in a separate CSC via telephone.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
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:
Adequacy of Progress Notes
Summary:
The progress notes of events in the investigation stage such as: CSC, consultation with the medical consultant and FCLS did not contain details.
Legal Reference:
18 NYCRR 428.5
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:

Safety factor selected focused on the BM's admission to smoking and testing positive for marijuana , but it did not specify how this impacted on her ability to care for the sibling.

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:

Safety factor selected focused on the BM's admission to smoking and testing positive for marijuana , but it did not specify how this impacted on her ability to care for the sibling.

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.

Issue:

Appropriateness of allegation determination

Summary:

...

Legal Reference:

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

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)
05/22/2015	12301 - Other Child - DC's Cousin, Female, 9 Days	12302 - Mother, Female, 19 Years	Inadequate Guardianship	Unfounded	Yes
	12301 - Other Child - DC's Cousin, Female, 9 Days	12303 - Grandparent, Female, 37 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	12301 - Other Child - DC's Cousin, Female, 9 Days	12304 - Aunt/Uncle, Female, 18 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	12301 - Other Child - DC's Cousin, Female, 9 Days	12304 - Aunt/Uncle, Female, 18 Years	Inadequate Guardianship	Unfounded	
	12301 - Other Child - DC's Cousin, Female, 9 Days	12303 - Grandparent, Female, 37 Years	Parents Drug / Alcohol Misuse	Unfounded	
	12301 - Other Child - DC's Cousin, Female, 9 Days	12304 - Aunt/Uncle, Female, 18 Years	Parents Drug / Alcohol Misuse	Unfounded	
	12301 - Other Child - DC's	12302 - Mother,	Parents Drug /	Unfounded	

Cousin, Female, 9 Days	Female, 19 Years	Alcohol Misuse	
12301 - Other Child - DC's Cousin, Female, 9 Days	12302 - Mother, Female, 19 Years	Inadequate Food / Clothing / Shelter	Unfounded
12301 - Other Child - DC's Cousin, Female, 9 Days	12303 - Grandparent, Female, 37 Years	Inadequate Guardianship	Unfounded

Report Summary:
The BM was 7 months pregnant with her 1st child. The MA had a 9-day-old infant and it was alleged the subjects were unable to properly care for the child. The MGM insisted the BM and the MA leave her home as she thought their presence would interfere with the return of her children who were in foster care. The MA and the BM indicated they would enter the shelter system to secure housing. During the investigation, the MA began the process of entering the shelter system. The BM gave birth on 7/7/15. ACS did not document anything about the BM's child or their whereabouts.

ACS confirmed there was DV in the MA's relationship, but this was not fully explored for the BM.

Determination: Unfounded | **Date of Determination:** 07/17/2015

Basis for Determination:
The allegations of I/F/C/S, PD/AM and IG were unsubstantiated for all 3 subjects. ACS noted there was no credible evidence to substantiate the allegations. ACS also noted the MGM and the BM were not primary caretakers for the infant. The MGM submitted to a drug screening and the results were negative; however, the allegation of PD/AM was not thoroughly explored for the BM or the BM.

OCFS Review Results:
NYCRO's review noted this was not a thorough investigation. Collaterals to address the DV between the MA and the infant's father confirmed this allegation. However, this allegation was not fully explored for the BM who gave birth on 7/7/15. The information did not continue to document any assessment of the BM's child or confirm where the BM resided after her child's birth.

It was unclear why the option to have the MA and the BM re-enter foster was not pursued; instead ACS agreed that the two should pursue entering the shelter system via DHS.

ACS met the BF of the 9-day-old infant, but did not issue the NOE for him.

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

Issue:
Failure to provide notice of report
Summary:
The NOE was not issued for the 9 day old infant.
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 comments to support the safety factors selected were not consistent with the documented information in the investigation.
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:

The comments to support the safety factors selected were not consistent with the documented information in the investigation.

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)
06/24/2014	14083 - Aunt/Uncle, Male, 14 Years	14082 - Grandparent, Female, 36 Years	Inadequate Guardianship	Unfounded	Yes
	14083 - Aunt/Uncle, Male, 14 Years	14081 - Father, Male, 20 Years	Inadequate Guardianship	Indicated	
	14083 - Aunt/Uncle, Male, 14 Years	14081 - Father, Male, 20 Years	Parents Drug / Alcohol Misuse	Unfounded	
	14083 - Aunt/Uncle, Male, 14 Years	14081 - Father, Male, 20 Years	Childs Drug / Alcohol Use	Unfounded	
	14083 - Aunt/Uncle, Male, 14 Years	14081 - Father, Male, 20 Years	Lack of Supervision	Indicated	
	14083 - Aunt/Uncle, Male, 14 Years	14082 - Grandparent, Female, 36 Years	Educational Neglect	Unfounded	
	14083 - Aunt/Uncle, Male, 14 Years	14082 - Grandparent, Female, 36 Years	Lack of Supervision	Unfounded	

Report Summary:

The family came from Virginia (VA) and entered the shelter system in New York in February 2014 because the mother was unable to find employment in VA and could no longer pay the rent. The mother was married to a man who had multiple medical issues with limited income from SSI and received child support for the child.

The SCR registered a report listing the PGM and the father of the SC named in the 2016 fatality report as the subjects. The maltreated child listed in this report was the father's 14-year-old sibling. For the purpose of this investigation, the father of the fatality report will be referred to as the adult sibling and the PGM as the mother.

The report alleged the mother had a clinical condition that did not allow her to “control” her 14-year-old child. It was alleged the adult sibling would “run the streets” with the 14-year-old and get into “trouble.” The report alleged that while the adult sibling and the 14-year-old child were “running the streets,” the adult sibling was shot in the face and the 14-year-old on the hand. neither sustained serious injuries. The report also alleged the adult sibling made the 14-year-old

child take drugs (ecstasy) and as a result the 14-year-old child fell asleep on the streets. The report also alleged the 14-year-old child had not attended school for the current school year and was suffering academically. It was alleged the mother was aware the 14-year-old child did not attend school; however, did nothing to get the child to attend.

The 14-year-old child informed ACS that he was not attending school because he was being bullied at school and had issues with the commute. The mother had made no effort to visit the school and alleged she was unaware the child was bullied at school. Initially, the mother was unaware of the school the child was attending and found the name of the school by going through her papers. The mother indicated the adult sibling had been kicked out of the shelter weeks prior to the report for not following the rules. The mother did not mention the adult sibling had any child care responsibilities for the child.

The mother indicated she had clinical issues, but had discontinued taking her medication years ago. The mother indicated she had concerns the child also had mental health issues, and had taken him to the hospital for an evaluation. However, concerning the child's routine medical visits, she alleged she had problems with the medical insurance. There was no documentation specifying the specific problems the mother had with obtain medical coverage.

At the inception of the investigation, the mother sent the child to reside with the father. ACS assessed the home and found it appropriate. However, the child was not following the rules and at one point the adult sibling showed up at the home without consent and threatened the child's father. At this point, it was agreed between the parents that the SC was returned to the shelter to reside with the mother. At the shelter it was reported the child was not following rules and would stay out over night.

The child was involved in criminal activities and had been arrested several times. The mother's involvement with addressing this is issue was not clearly documented.

Determination: Indicated	**Date of Determination:** 08/20/2014

Basis for Determination:
ACS substantiated the allegations of LOS and IG against the adult sibling for the child based on the fact that both he and the child were shot following an altercation. The allegation of CD/A was unsubstantiated against the adult sibling for the child because the child submitted to a drug screening and the result was negative. ACS unsubstantiated the allegation of PD/AM against the adult sibling, but did not provide a narrative to support their decision. ACS had not interviewed the adult sibling concerning the allegation as the family reported his whereabouts were unknown.

ACS unsubstantiated the allegations of EdN, LOS and IG of the MU by the mother noting there was no evidence to substantiate the allegations. ACS did not provide a narrative to support their decision. In addition, the investigation indicated there was information to support these allegations as the mother was the child's primary caretaker.

OCFS Review Results:
NYCRO's review found the current investigation was not thorough. ACS indicated the case against the adult sibling; however, at the time of the report, he had been kicked out of the shelter for not following the shelter rules. ACS did not document that the father had any caretaker responsibilities for the SC. The primary caretaker for the child was the mother who shortly after the investigation began, she sent the child to reside in Brooklyn with his father. The child failed to follow the rules at the father's home and allowed the adult sibling access to the father's home.

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

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
ACS did not fully focus on clarifying the information provided in the SCR report. Concerning the shooting of the SC, ACS accepted the information provided by the mother and the 14 year old sibling without seeking a relevant collateral

contact to determine the events leading up to this incident. In addition, ACS disregarded information obtained concerning the LOS,EdN and IG against the mother for the 14 year old child.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

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:

Contact/Information From Reporting/Collateral Source

Summary:

ACS did not make contact with the school to determine whether the SC was attending classes and attempted to confirm the information provided by the child and/or assess the mother's involvement with the school staff to determine whether she had made any attempts to address the child truancy. ACS might have breached confidentiality by providing the specific name of the source when asking whether the child knew this person.

Legal Reference:

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

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:

Failure to Provide Notice of Indication

Summary:

The NOI was not issued to the 14 year old child's father, or the mother or her husband .

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

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:

Appropriateness of allegation determination

Summary:

ACs indicated the report against the adult sibling who at the time of the report was not residing in the home. In addition, ACs did not specify the adult sibling's child care responsibilities. ACS had information to substantiate all the allegations against the mother; however, in the investigation conclusion it was documented that there was no credible evidence to indicate the report against the mother.

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 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:

The CONNECTIONS event list did not reflect that a NOE was issued to the child's father of the mother's husband.

Legal Reference:

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

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.

[redacted]

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

The mother was known to the SCR and ACS as a child. From 12/9/97 through 7/23/13 she was listed in nineteen reports; twelve were indicated. The substantiated allegations of these reports included Inadequate, Food, Clothing and Shelter; Lacerations, Bruises and Welts; Educational Neglect; Lack of Supervision; Lack of Medical Care and Sexual Abuse.

The mother had six siblings and was raised in a violent environment under the care of the maternal grandmother (MGM) who had "developmental delays" and used drugs. The MGM was unable to provide stable housing; therefore, the mother entered the shelter system at a very young age. In addition, the MGM was unable to meet the needs of the mother and her siblings and this resulted in ACS filing several Article Ten Neglect Petitions that either led to the mother and her siblings being remanded to the custody of the Commissioner of ACS or the family being placed under Court Ordered Supervision.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☐Yes ☒No

Preventive Services History

The family was placed under COS by ACS, as a result of a report registered by the SCR on 6/10/16. The father had physically assaulted the mother in the presence of the sibling. Despite numerous witnesses and injuries sustained by the mother, both parents, denied the allegations.

NYCRO's review of the FSS revealed ACS did not adequately follow up to assess the parents' relationship as it related to the domestic violence concerns. Specifically, ACS did not properly assess the safety factor regarding domestic violence as it related to the parents' ability to protect the children. During ACS' investigation of the 6/10/16 report, the mother denied the DV incident and fabricated a story to protect the father noting she had been hit by a car. For this reason, it was evident that ACS did not complete a full assessment of the mother's ability to protect the children. ACS was supervising the family without considering previous reports or concerns previously brought up by the CCF. The concerns previously reported to ACS by the CCF were about the sleeping arrangement for the children, home envioronment and lack of formula and

diapers for the SC. ACS did not ascertain the father's residence after the issuance of an OOP on 6/22/16, which order he stay away from the family

Due to the SC's death, ACS held a CSC and returned to the KCFC to petition a remand of the sibling. The remand was granted and the sibling was returned to foster care under the auspices of Edwin Gould Services' foster care agency.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?
☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/10/2016	Adjudicated Neglected	Article 10 Remand
Respondent:	033841 Mother Female 20 Year(s)	
Comments:	On 3/10/16, ACS filed an Article 10 Petition of Neglect and the sibling was remanded and placed in a non-kinship home. The mother was arrested on 3/9/16 and the father was already incarcerated. Therefore, the sibling was placed in foster care as neither parent could care for the child. After the BM was released, the sibling was discharged to the BM with COS on 4/26/16.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/10/2016	There was not a fact finding	There was not a disposition
Respondent:	033841 Mother Female 20 Year(s)	
Comments:	The father was added to the original March 2016 petition and a stay away OOP was issued on 6/22/16 against the father on behalf of the family.	

Have any Orders of Protection been issued? Yes	
From: 03/10/2016	**To:** Unknown
Explain: The 3/10/16 order of protection against the father continues active.	

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