Child Fatality Report

Report Identification Number: NY-16-067

Prepared by: New York City Regional Office

Issue Date: Jun 30, 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: 4 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 05/20/2016
Initial Date OCFS Notified: 07/01/2016

Presenting Information

The 7/1/16 report alleged the 4-month-old SC was in the care of the SM on 5/20/16 when he died from an unknown cause. The SM gave birth to the SC prematurely and the SC had some respiratory issues. On 5/20/16, the SC had problems breathing and 911 was called. The SC's cause of death was unknown, making the fatality suspicious in nature.

Executive Summary

The 4-month-old male SC died on 5/20/16. The ME listed the cause and manner of death as Undetermined.

The allegations of the 7/1/16 report were DOA/Fatality and IG of the SC by the SM.

ACS learned from LE that the SM fed the SC around 7:00 AM on 5/20/16. The SM placed the SC in a bouncy chair as he had been having problems with eating his food. At about 8:00 AM, she lay on her left shoulder in the bed and placed the SC on her right shoulder. The SM said the SC was on his blue striped blanket in the crook of her left arm. The SM placed her other arm over the SC's lower body parts and on top of one of the SC's stuffed animals. She received a call from the SC's BF at 9:58 AM. At the time she received the call, she observed the SC was unresponsive. The SC had mucous, blood, and food coming out of his nose. She called 911 and started CPR with the assistance of the operator. EMS arrived, provided medical assistance and transported the SC and SM to the hospital. The SM said the SC was born premature and had pre-existing medical conditions.

LE interviewed the hospital attending Dr. This Dr. had pronounced the SC dead at 10:56 AM. The Dr. found there were no trauma on the SC's body and no bleeding from the nose. The Dr. said she did not believe the SM fell asleep on the SC.

On 7/5/16, the SM said the SC was born premature and had medical issues. The SM informed ACS that she already spoke with LE and the hospital staff about what occurred, and if they believed that something was wrong, ACS would have been notified. ACS told the SM that ACS was supposed to be notified regarding any death of a child, but ACS was not and this was the reason for ACS involvement. The SM said she was reluctant to discuss the case circumstances and she referred ACS to speak with her shelter case manager (CM) and LE when the incident occurred. The SM informed ACS that the BF wanted to speak with ACS. ACS staff went outside to the front of the shelter. The BF "aggressively" walked up to ACS staff and became hostile about ACS investigation. ACS staff walked away and reentered the shelter.

On 7/7/16, a Child Safety Conference (CSC) occurred. The SM informed ACS the 16-year-old and 17-year-old half siblings resided with their father out of NYS. The 5-year-old half sibling (HS) was in the custody of his father and had been visiting the SM at the shelter. The SM said she was in treatment program at the Floating Hospital (FH), but had not been consistent with treatment since the SC's death. The outcome was for an Article Ten Petition to be filed against the SM, and a recommendation for court ordered supervision. The 15-year-old HS would be released to the BM with probation and PPRS. The petition was not accepted due to insufficient information to prove neglect.

On 7/15/16, the shelter program director (PD) informed ACS the SM arrived in the shelter on 12/27/15. The SM slept on a twin size bed with the SC. The room was equipped with a crib for the SC. The SM was told about safe sleep. The weekend visits for the 15-year-old HS began after the SC's death.

ACS reviewed the autopsy report and noted the cause and manner of death was undetermined. The final diagnosis was Gliosis Brainstem.

The documentation showed the 24-hour safety assessment was not completed timely as it was not completed until 7/5/16. CONNECTIONS reflected that the notice of existence (NOE) was not provided to the SM until 8/1/16.

On 11/7/16, ACS Unsub the allegations of DOA/Fatality and IG of the SC by the SM. ACS based the determination on information gathered from all parties involved including family members, medical staff, and investigative consultants. ACS received the ME report for the SC, and the autopsy report listed the final diagnosis as Gliosis Brainstem. The cause and manner of death was undetermined.

For much of the child welfare history of this family, Broome County DSS was involved in the investigation of reports registered by the SCR against this family.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Was the decision to close the case appropriate? Yes

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

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
NA

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	For the 7/1/16 report, ACS did not complete the 24-hour safety assessment within the required timeframe. ACS completed the 24-hour safety assessment on 7/5/16.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Failure to provide notice of report
Summary:	The SCR registered the report on 7/1/16. CONNECTIONS reflected that the notice of existence (NOE) was not provided to the SM until 8/1/16.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	ACS documentation did not reflect that diligent efforts were made to contact the SC's Dr.; contact was established with the SUNY Downstate Medical Center on 7/13/16, but was transferred to the Admittance Department fro further information.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/20/2016 **Time of Death:** 10:56 AM

Time of fatal incident, if different than time of death: 09:58 AM

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: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Other Household 1	Sibling	No Role	Male	5 Year(s)
Other Household 2	Sibling	No Role	Male	16 Year(s)
Other Household 2	Sibling	No Role	Male	17 Year(s)

LDSS Response

On 7/2/16, ACS visited the home of the father of the 5-year-old half sibling (HS). The father said the HS resided with him for about three years. ACS staff observed the HS was fine. Later, this father confirmed he had another 17-year-old male child through another relationship. There was a custody hearing in Kings County Family Court on behalf of the 5-year-old HS on 7/18/16; his father was the petitioner and SM the respondent. The case was dismissed.

On 7/5/16, LE informed ACS that the ME said the SC died from natural causes. LE said the ME also disclosed the SC had a medical condition.

On 7/6/16, ACS visited the SM's home and shelter staff said the SM was not home. The shelter PD said the SM was involved in a DV incident at about 2:30 AM on 7/6/16. The shelter PD said the SM told shelter staff she stabbed the BF (SC's father) in self-defense while they sat in a parked car. The SM was at the police precinct. The 15-year-old HS had been alone in the shelter unit, and had been residing in the unit since the SM's incident. ACS attempted to speak with the HS, but he left the shelter.

During the CSC, the SM said she had requested extended visiting nurse service (VNS) as the SC had continued to have episodes of breathing irregularities and choking. The SM stated the physicians and VNS insisted the symptoms were normal due to the SC being born premature. The SM said the SC was constantly sick, and she had taken the SC for hospital medical examinations. The SM said she last took the SC to the Dr. 2-3 days before his death on 5/20/16. The SM informed ACS that the 15-year-old HS did not like living at a shelter. He preferred to be with his friends in Broome

County (BC), NY. He was involved with the wrong crowd and took drugs/pills. On the day he ran away from home, he stole money from her. At about three weeks prior to 7/1/16, this HS had weekend visitation with the SM. The visitation started in May 2016. The 15-year-old saw a Probation Officer (PO) and attended the Way Home program.

On 7/21/16, the SM said she and the 15-year-old HS would meet with ACS in the shelter PD's office. the documentation noted that the HS seemed disinterested in speaking with ACS staff and he said he did not want to speak with ACS.

The PO said he monitored the 15-year-old HS's behavior, attendance in the Cultural Art Recreation and Educational Services (CARES) program and his participation in the Way Home program. Later, the PO said the SM informed him that the 15-year-old HS smoked marijuana. He said the HS was not being drug tested as there had been no disposition from the criminal court to administer drug test. Later, the PO said he was no longer the PO as of 8/19/16. ACS spoke with a supervisor who said the HS was scheduled to return to court on 9/15/16 and he was not on probation. This HS's case was assigned an Investigative PO. Later, the Investigative PO said the HS had been participating in the Center for Community Alternative (CCA) program.

On 7/29/16, the shelter PD informed ACS that she went with the SM to the hospital the night the SC passed away. The PD said that on 5/20/16, the SM called 911 and stated that the SC was not breathing. The PD had observed EMS and LE arriving at the shelter, and walked with them to the unit. The SM told her that she was talking to the SC's BF. The SM looked at the SC in his crib, and she saw that he was not breathing, and had blood coming out of his nose.

On 8/2/16, ACS received a call from the Bend Oregon Child Welfare Service staff who reported that a courtesy visit was conducted to the home of the BF of the 15-year-old HS on 8/1/16. The 16-year-old and 17-year-old half siblings were fine.

On 8/22/16, ACS inquired from the court liaison the status on the custody hearing between the SM and BF of the 5-year-old HS. A hearing occurred on 7/18/16; the petition was dismissed without prejudice.

On 11/1/16, the school attendance liaison reported the 15-year-old HS had regular school attendance.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation

			Outcome
032761 - Deceased Child, Male, 4 Mons	032762 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
032761 - Deceased Child, Male, 4 Mons	032762 - Mother, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 documentation reflected diligent efforts were not made to contact the EMS-ACS liaison. The documentation did not reflect ER personnel were interviewed, but information was obtained from LE who had interviewed the attending Dr.

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?	☐	☒	☐	☐

Explain as necessary:
At the time of the fatality, the only child with the SM was the SC. The 15-year-old HS had been residing in a facility.

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
On 8/12/16, ACS referred the SM for an evaluation. The documentation reflected that ACS asked the SM to submit to a drug test; she refused to speak with ACS.

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 15-year-old HS was involved with the Way Home program. He also received services through a probation officer.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The shelter assisted the mother with obtaining housing.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	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)
03/21/2016	12143 - Sibling, Male, 15 Years	12141 - Mother, Female, 34 Years	Inadequate Guardianship	Indicated	Yes

Report Summary:
The 3/21/16 report alleged the 15-year-old child ran away from the SM's home. The child was found on 3/21/16 at 1:54 AM stealing and breaking property inside of a private property. The SM was aware that the child has been located and had refused to retrieve the child. The child was in need of immediate care. The SM did not provide an alternate caregiver to get the child.

Determination: Indicated | **Date of Determination:** 05/20/2016

Basis for Determination:

ACS based the determination on the SM's failure to plan for her 15-year-old child. who was currently being held in a juvenile facility. The SM refused to pick up the child from the juvenile facility, even though it was explained to her that he would be released into her care if she would come get him.

OCFS Review Results:
The investigation was initiated timely. BC DSS spoke with the SM who said she recently had an infant (SC) who was premature, and she was unable to come to Binghamton. SM said she called friends and family, and no one returned her calls. SM said that this was on the now 15-year-old HS, and he would have to pay for what he did. LE said the HS would be charged and the BC DA's office would be notified. SM told ACS the HS ran away from home and he did not want to obey her house rules, and live with her anymore. SM made a police report, and she received a call around 4:30 AM informing her the HS was caught shoplifting in BC. The HS was placed in a facility. The SC was last observed on 5/10/16.

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

Issue:
Face-to-Face Interview (Subject/Family)

Summary:
BC DSS did not interview the 15-year-old HS despite that the child was located in BC.

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

Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/06/2015	12402 - Sibling, Male, 14 Years	12401 - Mother, Female, 34 Years	Educational Neglect	Unfounded	Yes
	12403 - Father, Male, 15 Years	12401 - Mother, Female, 34 Years	Educational Neglect	Unfounded	

Report Summary:
The 11/6/15 report alleged the SM was aware that her 14-year-old and 15-year-old children have excessive absences., and were absent 35 days from school this year. The children came from another district and records indicated they had zero credits and had not attended school for two years. Several attempts had been made to contact the SM; however, there had been no response.

Determination: Unfounded | **Date of Determination:** 01/04/2016

Basis for Determination:
ACS based the determination on information that showed the SM had not received a call from the school in Binghamton. The now 15-year-old child was enrolled in school in Brooklyn, and attended regularly since they moved to Brooklyn. The now 16-year-old child was enrolled and attended school out of state since he arrived. The information gathered from collateral contact showed they attempted to contact the SM but they were never able to leave her a message or make contact with her to tell her of her children not attending school.

OCFS Review Results:
The investigation was initiated timely. The report was registered with an address outside of NYC. The Broome County (BC) DSS CW interviewed the school staff and visited the reported address. The CW was informed by a resident that the SM no longer resided at the address. On 11/9/15, the CW contacted ACS informing that there was information that the SM relocated to Brooklyn around 10/23/15. On the same day, ACS visited the SM at the shelter where she was residing.

the SM informed ACS that the now 16 and 17 year-old children were residing out of state with their BF; they left to be with the BF on 11/2/15. The now 15-year-old said he and the SM left Binghamton about 3 months prior to 11/6/15.

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

Issue:
Failure to provide notice of report

Summary:
CONNECTIONS reflected that the Notice of Existence (NOE) was not provided to the father of the now 15-year-old HS.

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

Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/03/2015	12512 - Sibling, Male, 14 Years	12511 - Mother, Female, 33 Years	Educational Neglect	Indicated	Yes
	12901 - Sibling, Male, 15 Years	12511 - Mother, Female, 33 Years	Educational Neglect	Indicated	
	12902 - Sibling, Male, 16 Years	12511 - Mother, Female, 33 Years	Educational Neglect	Indicated	
	12902 - Sibling, Male, 16 Years	12511 - Mother, Female, 33 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 6/3/15 report alleged the SM was aware that all three children (the now 15, 16, and 17-year-old children) have an excessive amount of unexcused absences from school this year. All three children had absentee issues from school throughout the year, and more recently the three children continued to have an excessive amount of unexcused absences. The now 17-year-old had been absent 14 out of the more recent 19 school days, the now 16-year-old has been absent 11 out of the more recent 19 school days, and the now 15-year-old child has been absent 33 days while being late 19 times since January of 2015. All three children failed school due to their absentee issues.

Determination: Indicated | **Date of Determination:** 08/25/2015

Basis for Determination:
Broome County DSS based the determination findings which showed the three children missed significant amounts of school. During the investigation, the now 17-year-old child was hospitalized and the SM was not available for him when necessary. He was placed in the emergency shelter. During the investigation, all children resided in the SM's home, reportedly behaving and obeying rules.

OCFS Review Results:
The investigation began within 24 hours. BC DSS did not initially locate the family so a legal consultation occurred on 6/5/15. Documentation of the consultation reflected the efforts made to locate the family. On 6/9/10, the now 17-year-old child was at the hospital after having a medical episode. The SM told BC DSS that she would arrive shortly, but did not arrive. The child was brought to the emergency shelter for the evening. A legal consultation occurred on 6/10/15. The outcome was that the Legal department felt there was probably not enough to file a neglect petition. The SM was requested help to manage the children's behavior.

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

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

The documentation reflected that there were notes not entered contemporaneously as the events occurred on 6/11/15 but were not entered until 7/15/15.

Legal Reference:

18 NYCRR 428.5(a) and (c)

Action:

BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The Seven Day safety assessment was completed on 6/5/15; two days after the receipt of the report. The comment reflected the family's whereabouts were unknown, therefore BC DSS was unable to assess safety. A safety modification should have occurred on 6/10/15 as information was gathered.

Legal Reference:

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

Action:

BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:

Face-to-Face Interview (Subject/Family)

Summary:

The now 17-year-old child informed BC DSS of a DV incident in which the now 16-year-old HS hit the SM's paramour over the head with a beer bottle as he was fighting with the SM thereby causing the SM to sustain a black eye. The documentation did not reflect that this was addressed with the SM when she was interviewed.

Legal Reference:

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

Action:

BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/30/2015	12542 - Sibling, Male, 16 Years	12541 - Mother, Female, 33 Years	Educational Neglect	Unfounded	Yes
	12543 - Sibling, Male, 15 Years	12541 - Mother, Female, 33 Years	Educational Neglect	Unfounded	

Report Summary:

The 4/30/15 report alleged that the SM failed to ensure that the now 17-year-old and now 16-year-old children attended school. The two children had not attended school during the school year. One week prior to 4/30/15, the SM finally registered the two children in school; however, they had not attended.

Determination: Unfounded	**Date of Determination:** 05/18/2015

Basis for Determination:
Broome County unsubstantiated the allegations of EdN for the now 16 and now 17 y/o by the SM on the basis the SM made sure the children were enrolled in school and got on the school bus; however, the children defied the SM and developed a pattern of lack of school attendance.

OCFS Review Results:
Results of this review showed that BC DSS CPS made collateral contacts at the children's school and the family shelter residence. No contact was made with children's medical Dr. The 7-Day safety assessment and pre-determination safety assessment decision stated the safety factors did not rise to the level of immediate or impending danger of serious harm, but the assessment listed a factor that places the children in immediate danger or impending harm. The Risk Assessment noted the SM admitted she smoked marijuana and had a physical disability, but these assessments were not documented in the case progress notes.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-Day safety assessment decision stated the safety factors did not rise to the level of immediate or impending danger of serious harm, but the assessment listed a safety factor that placed the children in immediate of serious harm.

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

Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
The pre-determination safety assessment decision stated the safety factors did not rise to the level of immediate or impending danger of serious harm, but the assessment listed a safety factor that placed the children in immediate danger or impending danger of serious harm.

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

Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Adequacy of case recording

Summary:
The documentation was unclear if the school notified the SM regarding the children's unexcused absences. Assessment of the children's living environment was not documented. The Risk Assessment noted the SM admitted she smoked marijuana and had a physical disability, but these assessments were not documented in the case progress notes.

Legal Reference:
18 NYCRR 428.5(c)

Action:

BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Diligence of Efforts
Summary:
The documentation did not reflect CPS efforts to contact and involve the children's BF.
Legal Reference:
NYCRR 430.12D
Action:
BC DSS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/26/2015	12623 - Sibling, Male, 13 Years	12621 - Mother, Female, 33 Years	Inadequate Guardianship	Indicated	Yes
	12622 - Sibling, Male, 16 Years	12621 - Mother, Female, 33 Years	Lack of Medical Care	Indicated	
	12622 - Sibling, Male, 16 Years	12621 - Mother, Female, 33 Years	Inadequate Guardianship	Indicated	
	12624 - Sibling, Male, 15 Years	12621 - Mother, Female, 33 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 2/26/15 report alleged that the SM was aware that the now 17-year-old child broke his ankle on Saturday 2/21/15, and never took the child for medical care or treatment. The child could not walk on the ankle and was in severe pain. The SM had fled and took off leaving the child alone and did not make any adequate arrangements for his care. It was unknown where the child had been staying.

Determination: Indicated | **Date of Determination:** 04/23/2015

Basis for Determination:
BC DSS substantiated the allegations of IG and LMC for the now 17-year-old and added the allegation of IG for the now 16-year-old and 15-year-old by the SM on the basis the SM did not follow up with the now 17-year-old child's medical care or treatment. The now 17 and 16 year-old children was not enrolled in school, AWOL from a JCCA residential facility since 1/2015, and residing with the SM. The SM was homeless and resided in a variety of locations with various people.

OCFS Review Results:
BC DSS made diligent efforts, adequate collateral contacts and obtained relevant information from schools, Dr., hospital staff, community and public agencies. During the review period, there were sufficient and relevant face-to-face contacts with SC, siblings and SM. The Risk Assessment noted the SM admitted she smoked marijuana and had a physical disability, but these assessments were not documented in the progress notes. The pre-determination safety assessment stated the safety factors did not rise to the level of immediate or impending danger of serious harm, but the assessment listed factors that placed the children in immediate danger of serious harm.

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

Issue:
Diligence of Efforts

Summary:
the documentation did not include CPS efforts to contact and involve the half sibling's father.
Legal Reference:
NYCRR 430.12D
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The pre-determination safety assessment of 4/20/15 stated the safety factors did not rise to the level of immediate or impending danger of serious harm, but the assessment listed factors that placed the children in immediate danger of serious harm.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Adequacy of case recording
Summary:
The explanation of the substantiated allegations of IG of the now 15 and 16 year-old half siblings by the SM was not documented. There was credible evidence to add and substantiate the allegation of EdN and LS for all the half siblings. The SM failed to exercise care in enrolling the half siblings in to school and ensuring they attended.
Legal Reference:
18 NYCRR 428.5(c)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/08/2014	12643 - Sibling, Male, 13 Years	12641 - Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	Yes
	12643 - Sibling, Male, 13 Years	13082 - Other Adult - father of the now deceased child, Male, 33 Years	Parents Drug / Alcohol Misuse	Unfounded	
	12643 - Sibling, Male, 13 Years	12641 - Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Unfounded	
	12643 - Sibling, Male, 13 Years	13082 - Other Adult - father of the now deceased child, Male, 33 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 12/8/14 report alleged on 12/8/14, the SM and her live-in paramour were having an argument that turned physical

when the paramour grabbed the SM and put her in a bear hug in the presence of the now 15-year-old child. The now 15-year-old child got upset at seeing the SM in that position and the violence between the parents. The 15-year-old child started banging his head on the wall. The 15-year-old child passed out in the living room and he was shaking as if he had a seizure.

Determination: Unfounded	**Date of Determination:** 01/14/2015

Basis for Determination:
BC DSS unsubstantiated the allegations based on the family's account which noted the altercation between the SM and the paramour was verbal and that the child banged his head on the wall as a means of "comfort." The SM denied using drugs or alcohol to "the point of intoxication."

OCFS Review Results:
NYCRO's review found that this was not a thorough investigation. All relevant collateral contacts to assess the safety and risk of the child or the services needed were not made. The information gathered was documented verbatim and did not include additional inquiry for appropriate assessments. The documentation did not reflect that CPS staff attempted to obtain medical and educational reports concerning the child. There was no indication that CPS staff considered a legal consultation for this case. Based on the family's history it appeared that the SM's untreated condition and/or alcohol use had a negative impact on her ability to provide the basic needs of the child.

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

Issue:
Failure to provide notice of report
Summary:
The Notice of Existence was not issued for the non-custodial parents.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
There was no follow-up concerning the SM self reported diagnosis, the child's one day school suspension due to behavioral issues, and pending eviction. It was not established why the SM was being evicted.
Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
There was insufficient collateral contact such as the child's physician, relevant school officials, landlord, neighbors, relatives, and the foster care agency. There was no probing/exploring for additional information provided by collateral such as the school staff concerning the suspension or attendance. The hospital SW when she noted the child the had an "anxiety reaction."

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The determination safety assessment noted there were no safety factors, yet the SM continued to have children in care.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
BC DSS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Review of CPS History
Summary:
The review of the family's history was not thorough or not considered when assessing safety and risk or service needs.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
BC DSS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/31/2014	13071 - Sibling, Male, 14 Years	13061 - Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	Yes
	13072 - Sibling, Male, 16 Years	13061 - Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 10/31/14 report alleged that at about 9:00 AM on 10/31/14, the now 17-year-old and 16-year-old children arrived in the court to meet the SM and both children were under the influence of the drug K-2. The now 17-year-old child passed out at court and both children were hospitalized. The SM did not visit the hospital to admit and sign consent for medical treatment.

Determination: Unfounded | **Date of Determination:** 12/19/2014

Basis for Determination:
ACS unsubstantiated the allegation of IG based on the fact that the children were in foster care and under the supervision of the foster care agency, JCCA.

OCFS Review Results:
NYCRO's review revealed this was not a thorough investigation. The progress notes did not reflect that the interviews with the SM or the 13-year-old child addressed basic information for completing proper safety and risk assessments.

Relevant collateral contacts were not made with the 13-year-old child's school staff or Dr.. The NOEs were not issued to the non-custodial parents.

The RAP and the safety assessments did not reflect the use of critical thinking based on the information known about the family. Although the SM moved out of ACS' jurisdiction, a discussion should have been held with BCLDSS to consider legal action against the SM to request COS for the 13-year-old child.

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

Issue:
Failure to provide notice of report
Summary:
The Notice of Existence was not provided to the non-custodial parents.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
Documentation did not reflect there was a discussion with the now 15-year-old child's school staff to obtain information about his academic performance, attendance and/or the mother's involvement/demeanor. There was no contact with the now 15-year-old child's Dr.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The Seven Day safety assessment did not specify safety factors for the now 15-year-old child.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
ACS failed to assess the wellbeing of the now 15-year-old HS who was in the care of the SM because he was not listed as an alleged maltreated child in the report. Supervisory directives did not reflect ACS considered adding this HS as he was the only child in the SM's care.

Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Predetermination/Assessment of Current Safety and Risk
Summary:
Safety Decision 1 did not reflect the circumstances of the case. The SM had two children in care and did not seem able to properly meet the needs of the now 15-year-old HS. She took the now 15-year-old HS to reside with her paramour with whom she had engaged in a DV incident in the presence of the HS.
Legal Reference:
18 NYCRR 432.1(aa)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/28/2014	13202 - Sibling, Male, 16 Years	13201 - Foster Parent, Female, 41 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	13202 - Sibling, Male, 16 Years	13201 - Foster Parent, Female, 41 Years	Inadequate Guardianship	Unfounded	
	13203 - Sibling, Male, 14 Years	13201 - Foster Parent, Female, 41 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13203 - Sibling, Male, 14 Years	13201 - Foster Parent, Female, 41 Years	Lack of Supervision	Unfounded	
	13203 - Sibling, Male, 14 Years	13201 - Foster Parent, Female, 41 Years	Inadequate Guardianship	Unfounded	
	13202 - Sibling, Male, 16 Years	13201 - Foster Parent, Female, 41 Years	Lack of Supervision	Unfounded	

Report Summary:
The 10/28/14 report alleged the foster parent was failing to adequately supervise or to make an adequate alternate plan of care for two male children ages now 17 and 16 years. On a daily basis the foster parent locked the children out of the apartment between 5:30 and 6:00 AM when the foster parent left for work. The children were locked out of the building and the apartment until the parent returned home between 9:00 and 10:00 PM. The children did not have a way into the building. As a result, the children were unsupervised outside of the building as well as inside the hallways. The children did not have access to food and experienced hunger. The children did not have adequate clothing

Determination: Unfounded | **Date of Determination:** 12/26/2014

Basis for Determination:
ACS based the determination on the two children's denial the allegations were true. Both children denied being locked out of the home. The now 16-year-old child said he and the 17-year-old child often broke curfew and did not return to the home. The 16-year-old child also said they left the foster home and entered the hallway so they could use marijuana

where the foster mother (FM) was not present. The FM reported that the children often broke curfew and left the home without consent to use drugs. The allegation of IF/C/S was Unsub. Both children said the FM cooked and fed them well at mealtimes. The children said if they asked for food between meals, the FM had no problem giving food.

OCFS Review Results:
The investigation began timely. ACS established contact with the NY Foundling foster care agency. ACS interviewed the now 16-year-old, 17 year-old children, and the FM. The documentation reflected that the two children were voluntarily placed in foster care due to behavior issues. Both children were moved to a residential setting under the supervision of Jewish Child Care Association (JCCA) as of 11/19/14. The documentation did not reflect that the subject children's birth mother was contacted nor was she provided a NOE.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 11/3/14 safety assessment was inadequate as ACS did not identify the safety factors that actually placed the children in immediate danger.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The 12/26/14 safety assessment was inadequate as Safety Decision one was selected; the Safety Decision four should have been selected as the two children were placed in a higher level of care with JCCA.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Failure to provide notice of report
Summary:
The documentation and CONNECTIONS did not reflect that the children's mother was provided a NOE.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)

09/08/2014	13093 - Sibling, Male, 14 Years	13091 - Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	Yes
	13092 - Sibling, Male, 15 Years	13091 - Mother, Female, 33 Years	Excessive Corporal Punishment	Unfounded	
	13093 - Sibling, Male, 14 Years	13091 - Mother, Female, 33 Years	Excessive Corporal Punishment	Unfounded	
	13092 - Sibling, Male, 15 Years	13091 - Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	
	13092 - Sibling, Male, 15 Years	13091 - Mother, Female, 33 Years	Lacerations / Bruises / Welts	Unfounded	
	13093 - Sibling, Male, 14 Years	13091 - Mother, Female, 33 Years	Lacerations / Bruises / Welts	Unfounded	
	13094 - Sibling, Male, 3 Years	13091 - Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Unfounded	
	13094 - Sibling, Male, 3 Years	13091 - Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 9/8/14 report alleged when the SM became angry, she used excessive corporal punishment to discipline her now 17-year-old and 16-year-old by hitting the children with extension cords and as a result, the children had sustained scars. The children chronically ran away from home due to the ongoing conflict in the home. Recently, the children were picked up by the New Jersey PD from running away.

Determination: Unfounded | **Date of Determination:** 11/07/2014

Basis for Determination:
ACS unsubstantiated the allegations of PD/AM of the now 5-year-old child by the SM. ACS noted the SM denied drug use and she did not appear under the influence of drugs or alcohol. ACS unsubstantiated the allegation of XCP and LBW of the 17 and 16-year-old children stating the SM denied hitting children and the ACS worker found no marks or bruises on the children. ACS unsubstantiated the allegations of IG of the 5-year-old child by the SM. ACS explained that the two older children were in foster care and were being supervised. ACS unsubstantiated the allegations of L/B/W of the 5-year-old child by the SM as the child did not reside with the SM and did not have marks/bruises.

OCFS Review Results:
ACS did not add to the 9/8/14 report the allegations of I/F/C/S and IG of the now 15-year-old child by the SM. This was the only child for whom the SM was legally responsible. The agency did not provide an explanation for BM's failure to comply with shelter rules. (The SM was discharged from two shelters due to non-compliance). She failed to provide housing for the now 15-year-old child. ACS did not visit the now 15-year-old child's school to assess his safety within 24 hour or 7-day period 9/8 and 9/19. ACS did not complete a thorough investigation into the SM's alleged drug use in order to unfound the allegation of PD/AM.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
The 11/6/14 safety assessment was inadequate as ACS did not identify the safety factors which actually placed the children in immediate danger.

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

Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to

address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Appropriateness of allegation determination
Summary:
ACS inappropriately unfounded the allegation of XCP of the now 17-year-old HS who pointed to the healed bruises on his body and stated the SM inflicted them by using an extension cord and a stick.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
ACS did not complete a thorough investigation into the SM's alleged drug use in order to unfound the allegation of PD/AM even though ACS inappropriately addressed the allegation L/B/W of the now 5-year-old HS by the SM as the Allegation Information reflected the allegation L/B/W was regarding the two older half siblings.
Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/20/2014	13104 - Sibling, Male, 13 Years	13101 - Mother, Female, 32 Years	Inadequate Guardianship	Unfounded	Yes
	13104 - Sibling, Male, 13 Years	13101 - Mother, Female, 32 Years	Lack of Supervision	Unfounded	
	13105 - Sibling, Male, 14 Years	13101 - Mother, Female, 32 Years	Lack of Supervision	Unfounded	
	13105 - Sibling, Male, 14 Years	13101 - Mother, Female, 32 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 6/20/14 report alleged the SM had a history of not properly supervising the now 15-year-old and now 16-year-old children. The children run the streets and committ petty crimes. The SM did not follow through with their probation for their crimes. The children do not attend school. Late last night, the children snuck on a bus in NYC and made it to Syracuse when they were caught by the bus driver.

Determination: Unfounded | **Date of Determination:** 08/14/2014

Basis for Determination:
ACS based the determination on the findings that the SM took the necessary and appropriate steps when her children left the home without consent. The SM made a police report and found her way to Binghamton and Syracuse to get the

children. She was also planning appropriately for the children. The SM provided the basic care for her children and also took the appropriate steps to ensure the safety of her children.

OCFS Review Results:

The results of the review revealed ACS made efforts to contact collaterals such as SM's friends, shelter staff and the custodial father of now 5-year-old male child. ACS conducted several face-to-face contacts with the family. Throughout the investigation SM was not able to ensure the safety of the now 15 year-old and 16-year-old children; therefore an emergency removal was conducted by ACS on 8/11/14. ACS held a Child Safety Conference on 8/14/14; SM signed a voluntary placement for the 15 year-old and 16-year-old children. A family Services Stage was opened in September 2014.

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

Issue:

Diligence of Efforts

Summary:

There was no documentation of CPS efforts to contact and involve the children's BFs.

Legal Reference:

NYCRR 430.12D

Action:

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The Seven Day safety assessment was inadequate as ACS did not identify the safety factors which actually placed the children in immediate danger.

Legal Reference:

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

Action:

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The 8/14/14 safety assessment was inadequate as ACS did not identify the safety factors which actually placed the children in immediate danger.

Legal Reference:

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

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)

01/22/2014	13131 - Sibling, Male, 15 Years	13121 - Mother, Female, 32 Years	Educational Neglect	Indicated	Yes
	13133 - Sibling, Male, 12 Years	13121 - Mother, Female, 32 Years	Educational Neglect	Indicated	
	13131 - Sibling, Male, 15 Years	13121 - Mother, Female, 32 Years	Inadequate Guardianship	Indicated	
	13132 - Sibling, Male, 1 Years	13121 - Mother, Female, 32 Years	Lack of Supervision	Indicated	
	13133 - Sibling, Male, 12 Years	13121 - Mother, Female, 32 Years	Inadequate Guardianship	Indicated	
	13133 - Sibling, Male, 12 Years	13121 - Mother, Female, 32 Years	Lack of Supervision	Indicated	
	13131 - Sibling, Male, 15 Years	13121 - Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13132 - Sibling, Male, 1 Years	13121 - Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13132 - Sibling, Male, 1 Years	13121 - Mother, Female, 32 Years	Inadequate Guardianship	Indicated	
	13133 - Sibling, Male, 12 Years	13121 - Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13134 - Sibling, Male, 13 Years	13121 - Mother, Female, 32 Years	Lack of Supervision	Indicated	
	13134 - Sibling, Male, 13 Years	13121 - Mother, Female, 32 Years	Educational Neglect	Indicated	
	13131 - Sibling, Male, 15 Years	13121 - Mother, Female, 32 Years	Lack of Supervision	Indicated	
	13134 - Sibling, Male, 13 Years	13121 - Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13134 - Sibling, Male, 13 Years	13121 - Mother, Female, 32 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 1/22/14 report alleged the SM of the now 5-year-old, 15-year-old, 16-year-old and 17-year-old children, failed to adequately care for and supervise all her children. The SM failed to cook meals or feed her children adequately, they miss meals and go hungry ongoing, and have begged food of others. The children appeared dirty and were smelly, they followed a pattern of wearing the same ill fitting, soiled clothing for days. Older child/ren were out at night until 2-3:00 AM unsupervised. They were already on probation because they had been involved (when unsupervised) in repeated minor acts of juvenile delinquency. The mother also left the younger children at home unsupervised.

Determination: Indicated | **Date of Determination:** 04/07/2014

Basis for Determination:
BC DSS based the determination on finding of some credible evidence to substantiate that the SM failed to adequately supervise the children who were seen out at all hours of the night and were not getting to school regularly and were failing their classes. The SM failed to meet with school staff to address these issues and missed appointments with probation to address her children's needs. The children failed their grades in school and some already failed a grade. SM was allegedly engaged in prostitution but there had been no arrest. SM had sent her now 5-year-old child to stay with his father although there was an OOP.

OCFS Review Results:
BC DSS made some efforts to contact collaterals such as school , Probation officers, and SM's friends. BC DSS did not document contact with the family physician. BC DSS made one face-to-face visit to the home in January 2014. BC DSS did not document home visits for March and April, (documenting attempted contact with SM). BC DSS documented observing the now 5-year-old child once throughout the investigation. BC DSS found that the SM failed to follow through with any of the children's appointments and disregarded the OOP against BF of the now 5-year-old. Despite the OOP, the BC DSS Legal said that they would not be filing a violation and that BC would be letting that "run its course."

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

Issue:
Pre-Determination/Supervisor Review
Summary:
The Investigation Conclusion Narrative reflected that the allegation of IF/C/S was not addressed by the BC DSS although the allegation was unsubstantiated.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The LDSS staff noted the SM sent the now 5-year-old HS to reside with his father although she was aware there was an active OOP. The 3/26/14 safety assessment reflected the staff did not develop a Safety Plan. LDSS staff also documented several witnesses observed the children were out of the home unsupervised. LDSS staff did not formulate a safety plan with SM.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
BC DSS failed to document progress notes contemporaneously as events that occurred in January 2014 were entered in March 2014.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Date of SCR	Alleged	Alleged	Allegation(s)	Status/Outcome	Compliance

Report	Victim(s)	Perpetrator(s)			Issue(s)
12/13/2013	13173 - Sibling, Male, 2 Years	13171 - Mother, Female, 32 Years	Inadequate Guardianship	Indicated	Yes
	13173 - Sibling, Male, 2 Years	13171 - Mother, Female, 32 Years	Other	Unfounded	
	13173 - Sibling, Male, 2 Years	13172 - Father, Male, 48 Years	Inadequate Guardianship	Indicated	
	13173 - Sibling, Male, 2 Years	13172 - Father, Male, 48 Years	Other	Unfounded	

Report Summary:
The 12/13/13 report alleged that the Staten Island County Family Court Referee ordered a Court Ordered Investigation (COI) to return on 2/7/14.

Determination: Indicated | **Date of Determination:** 02/10/2014

Basis for Determination:
ACS based the determination on the agency being informed by BC DSS of filing of an Article Ten Neglect Petition on the SM and father of the now 5-year-old child, as he strangled the SM in front of the children. A full stay away OOP was put in place on behalf of the "present children." ACS requested legal documents and it was confirmed there was an outstanding stay away OOP when the SM sent the now 5-year-old to live with his father. ACS returned the child to the SM. Both parents did not comply with outstanding court orders. The allegation of Other was unfounded. Upon speaking with the sex offender monitoring unit, he had no restrictions and was allowed to have children in his care.

OCFS Review Results:
ACS made efforts to contact collaterals such as the now 5-year-old child's father, children, schools, daycare provider, Family Court Legal Service (FCLS), BC DSS, and preventive service provider. ACS did not make contact with DV consultant as directed by CPM. ACS conducted several face-to-face contacts with the family. ACS found that the children in the SF's care did not have adequate sleeping arrangements. ACS provided beds for the children. ACS found the SF had an active OOP, whereby he was barred from SM and children because of DV. ACS removed the now 5-year-old from the father's care on 1/17/14; he was returned to the SM in Binghamton.

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

Issue:
Diligence of Efforts

Summary:
There was no documentation of CPS efforts to contact and involve the now 17-year-old half sibling.

Legal Reference:
NYCRR 430.12D

Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
The 2/4/14 safety assessment was inadequate as ACS did not identify the safety factors that actually placed the children in immediate danger.

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

Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/25/2013	13182 - Sibling, Male, 13 Years	13181 - Mother, Female, 32 Years	Inadequate Guardianship	Unfounded	Yes
	13183 - Sibling, Male, 12 Years	13181 - Mother, Female, 32 Years	Inadequate Guardianship	Unfounded	
	13182 - Sibling, Male, 13 Years	13181 - Mother, Female, 32 Years	Lack of Supervision	Indicated	
	13182 - Sibling, Male, 13 Years	13181 - Mother, Female, 32 Years	Educational Neglect	Indicated	
	13183 - Sibling, Male, 12 Years	13181 - Mother, Female, 32 Years	Educational Neglect	Indicated	

Report Summary:
The 10/25/13 report alleged that the SM did not send her children, the now 15-year-old and 16-year-old, to school on a regular basis. They missed 11 days and had been tardy 5 times since the school year began. As a result the children, did not make any progress with their education plans. The SM had been contacted via multiple phone calls and a Person in Need of Supervision (PINS) letter this month, yet she failed to respond to any outreach. This situation was a pattern as last year the children were excessively absent.

Determination: Indicated | **Date of Determination:** 11/19/2013

Basis for Determination:
BC DSS based the determination on the children failing classes and the school filing a PINS on the now 15-year-old and 16-year-old children. The comments on the report cards stated irregular attendance effected grades. LE brought the now 16-year-old HS child home as he was hanging out at a store for four hours. The SM said to LE that she was overwhelmed caring for her now 5-year-old child and could not control the older children. The SM said they left the home without permission. The SM did nothing to fix the situation and refused services. The legal consultation reflected there was not enough evidence to file a Neglect petition. The allegation of IG was Unsub as the report was about EdN.

OCFS Review Results:
BC DSS made efforts to contact collaterals such as, schools, legal service, and physicians. BC DSS conducted several face-to-face contacts with the family. BC DSS consulted the Legal service and found that there was not enough evidence to file a Neglect petition. LDSS did not document if they provided the SM with services.

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

Issue:
Diligence of Efforts

Summary:
The documentation did not reflect efforts were made to contact father of the subject children.

Legal Reference:
NYCRR 430.12D

Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform Syracuse Regional Office (SRO) of the date of the meeting, who attended and what was

discussed.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 10/30/13 safety assessment was inadequate as the assessments listed a safety factor that placed the children in immediate danger of serious harm yet, the Safety Decision reflected the safety factors did not rise to the level of immediate or impending danger of serious harm.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The 11/19/13 safety assessment was inadequate as the assessment listed a safety factor that placed the children in immediate danger of serious harm yet, the Safety Decision reflected the selected safety factors did not rise to the level of immediate or impending danger of serious harm.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
BC DSS must submit a performance improvement plan that identifies the action the agency has taken or will take to address the citations identified in the fatality report. BC DSS must meet with the staff involved with this fatality investigation and inform SRO of the date of the meeting, who attended and what was discussed.

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

The SM was known to the SCR and ACS as a subject in seven reports dated: 5/26/06, 12/20/07, 2/12/10, 12/17/11, 10/21/12, 3/19/13, and 4/11/13. ACS closed the 6/6/06 SCR Duplicate report. The allegations of the 5/26/06 report were L/B/W, LS, and XCP of the now 16-year-old half sibling (HS) and 17-year-old HS, and LS of the now 15-year-old HS by the SM. On 7/21/06, ACS IND the report. The allegation of the 12/20/07 report was IG of the now 16-year-old HS, 17-year-old HS, and 15-year-old HS by the SM. On 2/15/08, ACS IND the report. The allegations of the 2/12/10 report were IG and LS of the now 16-year-old HS, 17-year-old HS, and 15-year-old HS by the SM and IG by the SM's paramour. On 3/5/10, ACS Sub the allegation of IG and Unsub the allegation of LS. The allegations of the 12/17/11 report were IF/C/S, LS, and IG of the now 16-year-old HS, 17-year-old HS, 15-year-old HS, and 5-year-old HS by the SM. On 1/12/12, ACS UNF the report. The allegations of the 10/21/12 report were IG and IF/C/S of the four half siblings by the SM and paramour (identified as the other parent). On 11/28/12, ACS Sub all the allegations of the 10/21/12 report. ACS UNF the 10/21/12 report. The allegations of the 3/19/13 report were IG and LS of the four half siblings by the SM. On 4/17/13, ACS UNF the 3/19/13 report. The allegations of the 4/11/13 report were IG and IF/C/S of the now 16-year-old HS and 15-year-old HS by the SM. On 4/26/13, ACS UNF the report.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 05/19/2016

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☐	☒	☐	☐

Closing

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

Required Action(s)

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

Preventive Services History

The Broome County (BC) DSS opened a Family Service Stage (FSS) on 8/22/05 to refer the family for respite care for HS who was then 5 years old. BC DSS staff met the Families First agency. The family did not receive PPRS because the SM said she only needed day care services. The staff directed the SM to contact central intake unit to request services. The FSS closed on 1/26/06. BC DSS also opened the FSS on 7/19/06. The half siblings were 5, 6, and 7 years old. The caseworker visited the home and engaged household members. The family did not receive PPRS. BC DSS closed the FSS on 1/4/07.

ACS opened a FSS on 10/23/07 after the SM visited ACS and requested services to address the half sibling's behavior. ACS provided referrals for evaluation, services at the Family Justice Center, housing, and employment services. ACS closed the FSS on 12/10/07. Subsequently, the family received Court Ordered Supervision from 1/10/08 to 3/23/09.

After the 11/6/15 investigation was completed on 1/4/16, ACS opened a FSS on 1/6/16. However, the mother declined PPRS. The Initial FASP reflected the family service plan was community advocacy, casework counseling, family support services, and case management services. The FSS was closed on 1/28/16.

The 5-year-old HS was in the custody of his father (who was not a subject of the fatality investigation). This HS and his father received PPRS.

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The NYF Family Services Progress Notes were not entered within the required timeframe. Some of the activities that occurred on 9/8/14, 9/9/14, 9/16/14 and 9/17/14 were entered on 11/25/14, 10/24/14, and 12/1/14, respectively.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The FSPN showed a note dated 3/10/15, entered 7/6/15; 4/27/15 entered 7/6/15; 5/4/15 entered 7/6/15 and 5/8/15 entered on 7/6/15. A note dated 5/29/15 was entered on 7/6/15.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Foster Care Placement History

ACS filed an Article Ten Neglect petition in Kings County Family Court on behalf of the three half siblings naming the SM as the respondent on 12/21/07. The allegation was IG pertaining to the SM's alcohol misuse, violent behavior and property destruction in the presence of the children. The judge remanded the half siblings to the care and custody of the Commissioner of ACS. The half siblings resided in non-kinship foster care under the supervision of the Little Flower agency until 1/10/08 when they were paroled to the SM under ACS supervision.

On 8/11/14, the mother signed a voluntary agreement (384 A) transferring the care and custody of the half siblings (who were then 14 and 15 years old) to the Commissioner of ACS. These half siblings had had a history of leaving home without parental consent; they misused marijuana and other illicit substances and their behavior was very difficult to manage. The half siblings were placed in a therapeutic foster home on 9/8/14. They were difficult to engage and their behavior did not improve. They were placed with the New York Foundling (NYF) agency family treatment foster care program and later transferred from NYF foster boarding home to residential treatment care. ACS had limited contact with the BM who resided in Binghamton. After the BM demanded the half siblings must return to her care, the judge returned them to the BM on 9/17/15.

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: SSL 384a - Transfer of Custody		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
08/11/2014	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	On 8/11/14, the SM signed a voluntary agreement (384 A) transferring the care and custody of the half siblings (who were then 14 and 15 years old) to the Commissioner of ACS. These half siblings had had a history of leaving home without parental consent; they misused marijuana and other illicit substances and their behavior was very difficult to manage. They were placed in a therapeutic foster home on 9/8/14. They continue to be difficult to engage and their behavior did not improve. They were placed with New York Foundling (NYF) agency, family treatment foster care program and later transferred from NYF foster boarding home to residential treatment care. ACS had limited contact with the BM who resided in Binghamton. The BM demanded that these two half siblings must return to her care. After the half siblings left the facility without permission and traveled to the BM's home, the judge returned them to the BM's care on 9/17/15.	

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** 06/06/2016
Explain: The documentation reflected that the SM had an order of protection (OOP) against the father of the 5-year-old half sibling. The documentation did not include the issuance and expiration dates.	

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