# Child Fatality Report

## Report Identification Number: NY-20-081

## Prepared by: New York City Regional Office

## Issue Date: Feb 19, 2021

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

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

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

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

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

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

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

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

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

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

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

## Abbreviations

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

## Case Information

**Report Type:** Child Deceased | **Jurisdiction:** Office Of Special Investigations | **Date of Death:** 09/10/2020
**Age:** 3 month(s) | **Gender:** Male | **Initial Date OCFS Notified:** 09/11/2020

### Presenting Information

The report alleged on 9/10/20, the SC, an otherwise healthy CH died. There was no explanation for the death. On the morning of 9/10/20, at an unspecified time, the BM left the SC at day care. Upon the SC's arrival, the day care operator, immediately put the SC to sleep. At 11:50 AM, the day care operator went to wake the SC in order to feed him at which time the operator found the SC unresponsive. The operator immediately called 911. At 12:15 PM, the SC was taken to the hospital where he was later pronounced dead.

### Executive Summary

The 3-month-old male child (SC) died on 9/10/20. As of 1/29/21, NYCRO had not received a copy of the autopsy report.

ACS learned that the incident occurred in a day care center that was licensed to serve six CHN, and was registered for four CHN. At the time the incident occurred, there were four CHN attending the day care including the SC. The other CHN enrolled were a 2-yo male, 3-yo female, and 11-month old male. The day care operator usually maintained an attendance log, but did not update the information for the date 9/10/20. The BM left the SC in the care of the operator at the day care center between 6:30 AM-7:00 AM on 9/10/20. The SC was asleep and alive at the time the BM left him in the care of the operator. The operator removed some of the SC's clothes, sat in the room and alternated between him lying in the bassinet and holding him in her arms. At an undetermined time, she laid him on her full-size bed in the room on his back. The SC was placed in the middle of the bed on his back surrounded by three pillows. He was not placed on the bed on a regular basis as he was usually placed in a bassinet during naps. She left him on the bed while she entered the bathroom to complete some chores, and then prepared food for the SC in the kitchen. The operator returned to the bedroom, touched his leg, but he did not move. She picked him up and his skin color seemed unusual. The operator obtained assistance from the day care assistant (her daughter) who took the SC, placed him on the floor and started CPR. They called 911 and were provided instructions. EMS and LE arrived and transported the SC to the hospital.

ACS findings showed the BM left the SC with the operator at the door of the day care center at around 6:45 AM. The BM was at work when the assistant called and told her something was wrong with the SC and she needed to go to the hospital. She traveled to the hospital where she learned about the incident. The BM said the SC was healthy. The BF learned about the incident when he received a telephone call from an individual.

On 9/14/20, the ME’s Office informed ACS the preliminary findings showed no signs of injuries and no diseases. Screenings were conducted, but the results were pending.

On 10/22/20, LE told ACS the investigation was closed as there was no evidence of criminality. There were no abnormal findings from the autopsy and the toxicology was negative for drugs in his system. The results from the neuropathology were pending.

On 11/7/20, ACS Unsub the allegation of DOA/Fatality and IG on the basis of no credible evidence. ACS explained that the operator expressed and demonstrated to ACS how she supervised the SC while in her care. The operator added that she was attentive to the SC's time for his meal, which led her to proceed to wake him. At that time, the operator found the SC unresponsive, she took appropriate measures of contacting 911 and notifying the parent. The day care assistant helped with supervision of all CHN at the day care including the SC. The assistant reported and demonstrated how she ensured

supervision and safety of the SC. The SC was placed in a bassinet upon arrival and alternated between the bassinet and being held. The SC was eventually placed in a bedroom where the operator remained with him as he rested. The operator left the room momentarily, and the assistant entered to ensure supervision was always maintained. Medical staff reported there was no indication of suffocation or foul play.

## 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?** Unable to Determine
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

**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:** | Contact/Information From Reporting/Collateral Source |
| **Summary:** | The documentation did not reflect ACS interviewed emergency room personnel regarding the SC. |
| **Legal Reference:** | 18 NYCRR 432.2(b)(3)(ii)(b) |
| **Action:** | ACS must submit a PIP 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 Investigation Progress Notes reflected that on 10/15/20, the day care operator informed ACS about burial of her child. However, ACS did not obtain information to clarify the operator's statement. |
| **Legal Reference:** | 18 NYCRR 428.5 |
| **Action:** | ACS must submit a PIP 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:** 09/10/2020 **Time of Death:** 12:43 PM

**Time of fatal incident, if different than time of death:** 11:50 AM

**County where fatality incident occurred:** Kings
**Was 911 or local emergency number called?** Yes
**Time of Call:** 12:01 PM
**Did EMS respond to the scene?** Yes
**At time of incident leading to death, had child used alcohol or drugs?** N/A
**Child's activity at time of incident:**

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] Other

**Did child have supervision at time of incident leading to death?** Yes
**If the child was in day care at the time of the fatality, was the day care program duly licensed or registered?** Yes
**Licensing/Registering Agency:** NYCDOHMH
**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 | 3 Month(s) |
| Deceased Child's Household | Father | No Role | Male | 38 Year(s) |
| Deceased Child's Household | Grandparent | No Role | Female | 52 Year(s) |
| Deceased Child's Household | Mother | No Role | Female | 35 Year(s) |

| Deceased Child's Household | Sibling | No Role | Female | 15 Year(s) |
|---|---|---|---|---|
| Deceased Child's Household | Sibling | No Role | Female | 11 Year(s) |
| Deceased Child's Household | Sibling | No Role | Male | 8 Year(s) |
| Other Household 1 | Day Care Provider | Alleged Perpetrator | Female | 32 Year(s) |
| Other Household 1 | Day Care Provider | Alleged Perpetrator | Female | 54 Year(s) |

## LDSS Response

On 9/11/20, New York City Department of Health and Mental Hygiene (DOH) personnel informed ACS about the incident. The documentation reflected that the Department of Education (DOE) was involved with the case.

On 9/11/20, ACS interviewed the day care operator and assistant at the day care center. The operator said prior to the time of the incident, there were no issues or concerns regarding the SC. According to the operator's account, the children in attendance played in the living room/play area. Later, on 9/15/20, operator provided additional information. She said she was in the room with the SC and alternated between him lying in the bassinet and holding him in her arms. A child arrived at about 9:15 AM, the operator received this child and called the day care assistant with whom she left the newly arrived child. The operator then brought the SC into a vacant room. The operator called the assistant who brought her 2-yo CH into the bedroom; the day care enrolled child was asleep in the pack n play. The assistant watched the SC as the operator cooked cereal. At about 10:00 AM, the 3-yo female enrolled child arrived at the center. The assistant's 2-yo CH was picked up by his father. The operator remained in the bedroom with the SC as he slept and then called the assistant to come to the room so she could prepare the SC's bottle. Upon returning to the bedroom she held the SC and she saw he was unresponsive.

The day care assistant said the operator placed the SC on the bed in her room surrounded by pillows. The assistant explained that she checked the SC a few times and saw him move. The assistant said the operator was between rooms where the SC was located and the kitchen preparing SC's bottle. The operator called out stating something was wrong with the SC. The assistant said she saw the operator holding the SC who seemed limp. She took him from the operator, placed him on the floor and began CPR while she told the operator to call 911. The operator dialed 911 and it was not going through. The assistant called 911 and handed the phone to the operator. During the follow up interview, the assistant said she the held the SC, who was asleep, as the operator prepared the meals for day care children. The assistant said she entered the room with the SC during the time the day care operator went to the kitchen to prepare his food. According to the assistant's account, the SC was on his back and asleep. The operator reportedly returned to the room where the SC was asleep, and assistant returned to the day care room. The assistant said her CH's father arrived to pick up the 2-yo, and the 3-yo day care CH arrived. The operator then called her to watch the SC. She left the day care room as the 3-yo CH played and the other CH rested in a pack n play. The SC was asleep but fussy as he moved. She gently rubbed his right arm, the operator returned; she went to the day care room and heard the operator call for her assistance.

On 9/11/20, BM said she did not believe the operator harmed the SC. Later, ACS informed the parents of bereavement and the BM did not accept the service.

On 9/11/20, the 8-yo SS said the SC did not seem ill prior to going to the day care center. The 15-yo SS said she helped the BM carry the SC to the car. He was fine. The 11-yo SS said the BM told them the medical personnel did not find anything to be wrong with the SC and said he died in his sleep.

On 9/17/20, DOH personnel said a decision was made to temporarily revoke/suspend the day care license effective 9/17/20. The documentation showed the assistant was the only approved personnel. There were no complaints regarding the day care; but was fined for having to many CHN under the age of two without proper staffing. Later, DOH informed

ACS the operator was a provider since 12/16/07. The assistant was a substitute since 10/13/06. Later, ACS received correspondence from DOH about the determination to suspend and seek revocation of the registration.

## Official Manner and Cause of Death

**Official Manner:** Pending
**Primary Cause of Death:** Pending
**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 NYC.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 056097 - Deceased Child, Male, 3 Mons | 056100 - Day Care Provider, Female, 32 Year(s) | DOA / Fatality | Unsubstantiated |
| 056097 - Deceased Child, Male, 3 Mons | 056100 - Day Care Provider, Female, 32 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 056097 - Deceased Child, Male, 3 Mons | 056099 - Day Care Provider, Female, 54 Year(s) | DOA / Fatality | Unsubstantiated |
| 056097 - Deceased Child, Male, 3 Mons | 056099 - Day Care Provider, Female, 54 Year(s) | Inadequate Guardianship | 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?** | ☐ | ☒ | ☐ | ☐ |
| Emergency Room Personnel | ☐ | ☒ | ☐ | ☐ |
| **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 day care operator informed ACS that she did not maintain an attendance log. The documentation did not reflect the hospital personnel were interviewed.

**Fatality Safety Assessment Activities**

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

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

**Fatality Risk Assessment / Risk Assessment Profile**

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

**Explain:**
The BM said she was not interested in services for herself. The 11-yo and 8-yo SS would possibly receive bereavement counseling through school.

## Placement Activities in Response to the Fatality Investigation

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?** | ☐ | ☒ | ☐ | ☐ |
| **Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?** | ☐ | ☒ | ☐ | ☐ |

**Explain as necessary:**
The incident occurred in a day care setting.

## Legal Activity Related to the Fatality

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

## Services Provided to the Family in Response to the Fatality

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Intensive case management** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Family or others as safety resources** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| **Other** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?** No
**Explain:**
The mother said the 8-yo and 11-yo CHN would possible receive bereavement counseling through school.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** No
**Explain:**
The mother said she was not interested in services for herself currently.

## History Prior to the Fatality

### Child Information

| | |
|---|---|
| **Did the child have a history of alleged child abuse/maltreatment?** | No |
| **Was the child ever placed outside of the home prior to the death?** | No |
| **Were there any siblings ever placed outside of the home prior to this child's death?** | No |
| **Was the child acutely ill during the two weeks before death?** | No |

### Infants Under One Year Old

**During pregnancy, mother:**
- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☒ Was not noted in the case record to have any of the issues listed

**Infant was born:**
- ☐ Drug exposed
- ☐ With fetal alcohol effects or syndrome
- ☒ With neither of the issues listed noted in case record

## CPS - Investigative History Three Years Prior to the Fatality

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 02/28/2020 | Sibling, Female, 15 Years | Father, Male, 38 Years | Inadequate Guardianship | Unsubstantiated | Yes |

**Report Summary:**
The report alleged in February of 2020, the BF woke the 15-yo SS and instructed her to take out the trash. When the 15-yo SS did immediately respond, the BF broke a plate on her head and then struck her. Further details were unknown.

| **Report Determination:** Unfounded | **Date of Determination:** 04/11/2020 |
|---|---|

**Basis for Determination:**
ACS unsubstantiated the allegation of the report on the basis of no credible evidence. The SS had been residing with her aunt beginning November of 2019 and did not spend the weekends/nights at the BM's home.

**OCFS Review Results:**
ACS initiated the investigation within the required timeframe. The BM denied the allegations of the report. She said that following the CPS investigation of 10/11/19, she made a family arrangement for the SS to reside temporarily with her aunt. The BF denied the allegations of the report and he said the SS did not reside in the home. He explained that he spoke to the CHN but if they did not listen he hits them with an open hand on their buttocks. The 7-yo and 11-yo SS denied the 15-yo SS was hit in the head with a plate by BF.

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

**Issue:**
Timely/Adequate Case Recording/Progress Notes

**Summary:**
ACS did not contemporaneously enter the progress notes. An event occurred on 2/28/20 but was not entered until 4/1/20.

**Legal Reference:**
18 NYCRR 428.5

**Action:**
ACS must submit a PIP 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) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 10/11/2019 | Sibling, Female, 14 Years | Mother, Female, 34 Years | Inadequate Guardianship | Unsubstantiated | Yes |
| | Sibling, Female, 14 Years | Stepfather, Male, 37 Years | Inadequate Guardianship | Unsubstantiated | |

**Report Summary:**
The report alleged the BF of SC hit the 14-yo SS in the head with a plate. As a result, the plate broke into four pieces, but it was unknown if the 14-yo SS sustained physical injuries. The BF punched the 14-yo SS in the face. On 10/11/19, the BF yelled at the 14-yo SS and advised her she could no longer reside in the home. The BM did not intervene and the adults not make an adequate plan for the SS.

| **Report Determination:** Unfounded | **Date of Determination:** 12/10/2019 |
|---|---|

**Basis for Determination:**
ACS unsubstantiated the allegation of the report on the basis of no credible evidence.

**OCFS Review Results:**
ACS initiated the investigation within the required timeframe. On 10/11/19, ACS visited the home, observed the 14-yo SS, and found she did not have marks or bruises. During the interview with ACS, the BM said LE responded to the home after the family experienced difficulty managing the SS's behavior. However, the SS denied she misbehaved in the home as she completed her assigned household chores. She said she wanted to reside with her MA because of the conflict with her parents. The BF denied the allegations of the report.

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

**Issue:**
Timely/Adequate Case Recording/Progress Notes

**Summary:**
ACS did not contemporaneously enter progress notes. An event occurred on 10/11/19 but was not entered until 12/9/19.

**Legal Reference:**
18 NYCRR 428.5
**Action:**
ACS must submit a PIP 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:**
The documentation did not reflect ACS contacted and interviewed LE regarding the incident.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(b)
**Action:**
ACS must submit a PIP 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.

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

There was no CPS investigative history more than three years prior to the fatality.

## Known CPS History Outside of NYS

There was no known CPS history outside the NYS.

## Provider Oversight/Training

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Did the provider comply with discipline standards?** | ☒ | ☐ | ☐ | ☐ |
| **Was a Criminal History check conducted?**<br>**Date:** 09/11/2020 | ☒ | ☐ | ☐ | ☐ |
| **Was a check completed through the State Central Register?**<br>**Date:** 09/11/2020 | ☒ | ☐ | ☐ | ☐ |
| **Was a check completed through the Staff Exclusion List?**<br>**Date:** | ☐ | ☐ | ☐ | ☒ |

## Legal History Within Three Years Prior to the Fatality

**Was there any legal activity within three years prior to the fatality investigation?** There was no legal activity

**Recommended Action(s)**

**Are there any recommended actions for local or state administrative or policy changes?** ☐Yes ☒No

**Are there any recommended prevention activities resulting from the review?** ☐Yes ☒No