Child Fatality Report

Report Identification Number: NY-21-134

Prepared by: New York City Regional Office

Issue Date: Jun 10, 2022

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 12/24/2021
Initial Date OCFS Notified: 12/24/2021

Presenting Information

The SCR report alleged on 12/23/21, the SM put the SC to bed in his crib. On 12/24/21, between 4:00AM and 5:00AM, the SM went to check the SC and found him breathing. At 9:00 AM when the SM next checked the SC, she noticed that his lips had turned dark blue and he was unresponsive. At that time, he was on his back in the crib. At 9:06 AM, the SM called 911 and the operator instructed her on how to perform CPR on the SC. She performed CPR until LE arrived at 9:13 AM. The SC had no visible injuries, and was an otherwise healthy CH. The SM had no explanation for the SC's death. The 12-yo, 11-yo, 7-yo, and 4-yo siblings and father had unknown roles.

Executive Summary

The 2-month-old male child (SC) died on 12/24/21. The final autopsy report listed the cause of death as acute rhinoviral/enteroviral interstitial pneumonia and the manner of death as natural. The allegations of the 12/24/21 report were DOA/Fatality and IG of the SC by the SM.

The SC and four male SSs ages 12, 11, 7, and 4 years old resided with the SM. The SC's father did not reside in the home and was not the father of the SSs. The fathers of the other CHN were not involved with the family.

According to the SM, on 12/21/22, the SC was seen for a wellness check and was given vaccinations. The next day, the SC had a fever and his legs were swollen. The SM called the pediatric clinic and was told by medical staff to keep the SC home, put cool towels on SC's legs, and administer Tylenol. The SM did as advised. The SM also gave the SC nasal suctions and humidifier with Vicks in it as the child had been congested a few days before. The SM gave the SC Tylenol once on the night of 12/22/21 and at 4:00AM on 12/24/21, the SM fed the SC and placed him in the crib in a supine position; there were no items in the crib. The SM awoke at 8:00 AM, and when she entered the bedroom she saw the SC looked stiff, and lips were dark. The SM grabbed the SC and screamed for assistance. The SM ran to the 12-yo SS bedroom and told him to call 911 from his phone as hers was dead. The 12-yo called 911 at about 8:00AM. EMS arrived, and the SC was transported to the hospital where he was pronounced dead.

On 12/24/21, the ME informed ACS that no foul play was present, but the autopsy was still pending. Photos were taken and nothing appeared to be abnormal. Several tests were completed but the results were still pending.

On 12/28/21, ACS held a conference and the decision was made to continue with court ordered supervision, PPRS, homemaking services, and bereavement counseling.

On 1/4/22, ACS discussed with Family Court Legal Service (FCLS) and a motion was filed in Family Court on 2/14/22. Court ordered supervision was extended.

On 2/14/22, ACS made a referral to a service provider for the SM to re-engage in clinical health services.

On 2/23/22, ACS substantiated the allegation of IG of the SC by the SM. Throughout the course of the investigation, there was credible evidence found to substantiate the allegation as the SM who was the sole caretaker of the children had a clinical health diagnosis and was not engaged in any clinical health services.

ACS unsubstantiated the allegation of DOA/Fatality of the SC by the SM. There was no credible evidence found to substantiate the allegation as there was no evidence the actions or inactions of the SM contributed to the death of the SC.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
Sufficient information was gathered to make determination for all allegations.

Was the decision to close the case appropriate? N/A

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:	The 24-Hour safety assessment was not completed timely. The 24-Hour safety assessment was not completed until 12/28/21.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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 reflected the family had homemaking services; however, ACS did not interview the homemaker to obtain additional information.
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:	Appropriateness of allegation determination
Summary:	The narrative provided for the substantiation of the allegation of IG did not provide any information on the impact on the SSs. Also, the SCR report did not allege IG for the SM's diagnosis.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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: 12/24/2021 **Time of Death:** 10:28 AM

Time of fatal incident, if different than time of death: 09:00 AM

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

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

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ Other:

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	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Other Household 1	Father	No Role	Male	32 Year(s)

LDSS Response

Upon the receipt of the report, the Specialist contacted the mother who denied DV, substance abuse, and clinical health concerns. The mother refused to have the Specialist interview the children and blamed the infant's death on vaccines. The SM said the SC's body movements changed, and he had a fever after he was vaccinated. She said she was told to administer Tylenol, which she did. ACS observed the four SSs to be well. The MGM was visiting from out of state.

On 12/24/21, LE informed ACS there were no concerns for the home environment.

On 12/24/21, ACS interviewed the Case Planner (CP) who also reported no concerns. The CP provided information regarding the services in which the mother was engaged and reported she had a face-to-face visit with the family on 12/16/21 and a video visit with them on 12/24/21 following the SC's death. According to the CP, the SM told her she was up until 4:00 AM with the SC and she awoke at around 8:00 AM to check him. The SC was usually up every two hours, so it was odd when he did not get up at 8:00AM. The SM said she saw the SC was not breathing and called 911. EMS arrived and performed CPR.

On 12/24/21, medical personnel stated the SC was pronounced dead on scene at 9:20AM and confirmed the SC had a wellness check on 12/21/21. There were no visible signs of trauma or bruising.

The 12-yo SS told ACS he did not want to speak with ACS about the death. The 11-yo said he recalled waking up to the SM yelling about the child. He said he entered the bedroom where the SM was located, and he saw the SM giving CPR to the SC. The 12-yo SS was on the phone with 911. ACS observed the 4-yo SS and noted the child appeared well.

On 12/28/21, a conference occurred. The SM's account was similar to the one she provided on 12/24/21. ACS also addressed concerns of DV between the SM and father of the SC, and the struggles with getting the children to school on time. Regarding the DV, SM said she was unaware the OP against the father was still active as the criminal court case ended in November 2021. The SM noted she had improved in getting the children to school on time, but said after the SC's birth she had difficulty keeping up with the children's schedule; however, homemaking services were in the home. ACS attempted to contact the father of the SC; however, none of the attempts were successful.

On 1/5/22, ACS visited the SSs schools which were in the same building. School staff members were concerned regarding the 7-yo SS clothing since he was not always appropriately dressed for the weather. The 11-yo said the father of the SC

had been in the home. He said the SM and father argue often but did not know what they argued about as the SM told them to stay in their rooms. The 12-yo said he was in his bedroom sleeping and the SM entered the room screaming the SC was not breathing. The SM took his phone and called 911 and while on the phone she performed CPR on the SC. He said he and his siblings went to a neighbor's home until the MGM arrived.

A motion was filed in Family Court on 2/14/22. Court ordered supervision was extended.

On 2/14/22, ACS made a referral to a service provider for the SM to re-engage in clinical health services.

On 2/23/22, ACS indicated the report.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a 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)?Yes

Was the fatality referred to 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
060406 - Deceased Child, Male, 2 Mons	060407 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
060406 - Deceased Child, Male, 2 Mons	060407 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
According to ACS, the SM declined to sign a HIPPA for ACS to speak to the primary care physician

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:
At the time of the fatality, the family had court ordered supervision.

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 family was under court order supervision at the time of the SC's death.				

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
At the time of the fatality, the family had PPRS and court ordered supervision.

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:
At the time of the fatality, the family had PPRS and court ordered supervision. According to ACS, during a conference, ACS offered bereavement and trauma focused therapy. The PPRS case notes reflected that due to the death of the SC and the SM being overwhelmed with emotions, the agency would explore these particular services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Services were offered to the mother who initially declined; however, the agency continued to encourage the mother to participate.

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? N/A
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

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

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

CPS - Investigative History Three Years Prior to the Fatality

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

03/07/2021	Sibling, Male, 10 Years	Other - father of the deceased child, Male, 31 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 6 Years	Other - father of the deceased child, Male, 31 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 11 Years	Other - father of the deceased child, Male, 31 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 3 Years	Other - father of the deceased child, Male, 31 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The 3/7/21 SCR report alleged that the father who had an OP against him went to the SM's home on 3/6/21, to try to talk to her. He grabbed the SM by the neck and pushed her into the apartment where the 8-yo and 4-yo were present. The father was arrested. The SM had an unknown role.

Report Determination: Indicated | **Date of Determination:** 05/06/2021

Basis for Determination:
ACS documented there was credible evidence to support the allegations. It was confirmed that the father assaulted the SM on 3/6/21 while the CHN were present in the home. The CHN did not sustain any injuries. The father confronted the SM in the hallway and pushed her into her apartment and choked her. There was already an OP in place for the SM against the father from an incident that occurred on 3/1/21.

OCFS Review Results:
ACS initiated the investigation timely and made the appropriate contacts and referrals. For the duration of the investigation, ACS staff assessed the safety of the children. There was evidence of supervisory involvement and guidance.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Notes were not entered contemporaneously. For example, events occurred on 3/24/21 but was not entered until 5/5/21.
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:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
The documentation did not reflect ACS interviewed the subject of the report, the SM's former paramour (father of the SC).
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
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)
03/13/2020	Sibling, Male, 9 Years	Mother, Female, 28 Years	Educational Neglect	Substantiated	Yes
	Sibling, Male, 9 Years	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 10 Years	Mother, Female, 28 Years	Educational Neglect	Substantiated	
	Sibling, Male, 10 Years	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Educational Neglect	Substantiated	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Years	Mother, Female, 28 Years	Lack of Medical Care	Substantiated	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Lack of Medical Care	Substantiated	

Report Summary:
The 3/13/20 SCR report alleged that the 10-yo SS had been absent 50 days, and the 9-yo and 5-yo SS's had been absent 48 days for the school year 2019-2020. As a result, all of the CHN were failing. The SM was aware and failed to adequately address the situation.

Report Determination: Indicated | **Date of Determination:** 05/12/2020

Basis for Determination:
ACS indicated the 9-yo SS was absent from school 51 times and late 29 times, the 10-yo SS was absent 53 times and 20 times, and the 5-yo SS was absent 51 times and late 31 times for the school year 2019-2020. The SM said she did not know why her CHN were absent that many times. According to school staff, they met with the SM five times to address the CHN's attendance, but the CHN continued to be absent. The three CHN also did not log on to complete remote learning since the pandemic began. The SM was also contacted during the school year.

OCFS Review Results:
ACS initiated the investigation in a timely manner and made the appropriate contacts which included contact with school staff. On 4/7/20, ACS opened a service case, and on 5/8/20, ACS filed a 1034 petition in court to gain access to the CHN which was granted. ACS attempted to file a neglect petition; however, it was not accepted in court.

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

Issue:
Appropriateness of allegation determination

Summary:
ACS inappropriately IND the allegation of EdN of the 5-yo SS by the SM. ACS did not apply the appropriate legal standard to IND this allegation regarding the 5-yo SS.

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

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)
10/27/2019	Sibling, Male, 9 Years	Day Care Provider, Female, 53 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 9 Years	Day Care Provider, Female, 53 Years	Lack of Supervision	Unsubstantiated	

Sibling, Male, 9 Years	Day Care Provider, Female, 53 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 4 Years	Day Care Provider, Female, 53 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 4 Years	Day Care Provider, Female, 53 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 4 Years	Day Care Provider, Female, 53 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 10 Years	Other - child care worker, Female, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 9 Years	Other - child care worker, Female, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 4 Years	Other - child care worker, Female, 27 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 10 Years	Day Care Provider, Female, 53 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 10 Years	Day Care Provider, Female, 53 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Male, 10 Years	Day Care Provider, Female, 53 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 10 Years	Day Care Provider, Female, 53 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 10 Years	Day Care Provider, Female, 53 Years	Swelling / Dislocations / Sprains	Unsubstantiated

Report Summary:
The 10/27/19 SCR report alleged that on a regular basis, the daycare owner and her staff members smoked marijuana and drank while caring for the 10-yo SS, 9-yo SS, and 4-yo SS, and multiple other CHN. While impaired, the staff was often loud, and rowdy, and they failed to provide adequate supervision for the CHN. The report further alleged that while the staff were not supervising the CHN, the 10-yo SS was physically assaulted by another CH and sustained a swollen, bruised eye. The role of the SM was unknown.

Report Determination: Unfounded | **Date of Determination:** 12/26/2019

Basis for Determination:
ACS unfounded the report on the basis of no credible evidence. The 10-yo SS said another CH was throwing toys at him. He was hit in the eye with a toy. The 10-yo, 9-yo, and 4-yo SSs did not report any concerns or fear regarding the daycare and said the daycare provider treated them well.

OCFS Review Results:
ACS initiated the investigation timely and made the appropriate contacts. The adults were properly notified and there was evidence of supervisory involvement.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/07/2019	Sibling, Male, 9 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No

Sibling, Male, 9 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 8 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 8 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 4 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 4 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 2 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 2 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
The 5/7/19 SCR report alleged there were ongoing issues with the condition of the home in which the 9-yo SS, 8-yo SS, 4-yo SS, and 2-yo SS resided. The conditions of the home were deplorable and unsanitary. There was rotting food and garbage throughout the home and on the walls, clothes piled on the floor throughout the home, and objects blocking the egress. The report alleged the SM was aware but was not addressing the situation.

Report Determination: Unfounded | **Date of Determination:** 07/05/2019

Basis for Determination:
ACS documented there was no credible evidence to substantiate the allegations. ACS assessed that adequate provisions were in place for the four CHN. ACS made collateral contact with outside sources that expressed no concern for the SM's parental ability. ACS observed the shelter unit to not be deplorable, but rather that the SM lived in a cramped space for her family size of five. ACS spoke with the shelter staff who said the deplorable conditions reported were not an ongoing occurrence.

OCFS Review Results:
The report was initiated timely and there was immediate contact with the family. There was evidence of supervisory involvement. The appropriate notices were provided.

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

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

The SM was known to the SCR and ACS in one case dated 8/17/18. The allegations of the 8/17/18 report were IG, LMC, and B/S of the 4-yo SS by the SM. On 10/26/18, ACS UNF the report and closed it with no services required.

The 4-yo SS was known as a non-confirmed maltreated CH in a report dated 9/12/18. The allegations of the 9/12/18 report was IG, L/B/W, and S/D/S of the 4-yo SS by the daycare provider one (DCP1) and PD/AM of an unknown CH by a daycare provider two (DCP2). The SM was listed as having no role. On 11/9/18, ACS UNF the report.

The 7-yo SS was known as a non-confirmed maltreated CH in a report dated 11/6/18. The allegation of the 11/6/18 report was IG of the 7-yo SS by the DCP3 and DCP4. The SM was listed as having no role. On 1/4/19, ACS UNF the report.

Known CPS History Outside of NYS

The SM had a history in the state of North Carolina. Granular details of the reports were not known; however, ACS learned there were concerns regarding drug and alcohol use.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 04/07/2020

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: 04/07/2020

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☐	☒	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☐	☐	☒	☐
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?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

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?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
During the 3/13/20 investigation, ACS opened a service case on 4/7/20.

Required Action(s)

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

Issue:	Adequacy of Progress Notes
Summary:	The notes reflected that on 4/22/21, ACS documented that the family was assessed via WhatsApp video messenger; however, no details were provided regarding the video conference.
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:	Adequacy of Progress Notes
Summary:	The documentation reflected a discrepancy with the note that had an event date of 9/24/20 a face-to face to the case address. The note narrative reflected that the visit to the case address occurred on 10/1/20; the entry date of the note.
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:	Timely/Adequate Case Recording/Progress Notes
Summary:	The PPRS notes were not entered contemporaneously. For example, and event occurred on 2/8/21 but was not entered until 11/15/21.

Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a corrective action plan to OCFS within 45 days regarding its actions to address the identified issue. ACS must include its policies for PPRS regarding Progress Notes documentation. ACS must ensure the PPRS meet with its staff to address this issue, and inform OCFS of the date of the meeting, who attended, what was discussed and the action plan.

Preventive Services History

ACS opened a service case on 4/7/20 as the now 12-yo, 11-yo, and 7-yo SSs had excessive absences and latenesses which impacted their academic performance resulting in doubtful promotions and the SM had untreated clinical health issues and a history of substance misuse. The shelter unit where the family resided was also observed to be in deplorable condition.

The initial FASP reflected the service plan for the SM included: parent training, DV services, clinical health services, diagnostic evaluation, and drug counseling treatment. The CHNs service plan included: case management services, diagnostic evaluation, and preventive services for CHN.

The 11/3/20 FASP reflected that an Article Ten Neglect petition was filed naming the SM as the respondent. The family was under court ordered supervision. The CHN were released to the SM with the conditions that the SM continue to meet the CHNs educational and medical needs. The SM was to comply with PPRS and homemaking services. The SM was to engage in clinical health services and also complete a comprehensive evaluation.

The 11/3/21 FASP reflected the family was enrolled in counseling services and was receiving parenting skills classes and homemaking services.

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: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/08/2020	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	The 3/7/21 investigation reflected that on 5/8/21, a 1034 petition was filed and the access order was granted by the Family Court. SM was not compliant with ACS and was not allowing ACS to see the CHN.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/22/2020	There was not a fact finding	There was not a disposition
Respondent:	060407 Mother Female 30 Year(s)	

Comments:	On 7/22/20, ACS filed an Article Ten Neglect Petition in Family Court naming the SM as the respondent. According to ACS, ACS requested a remand on 7/22/20. A Child Safety Conference (CSC) occurred with the SM on 7/21/20 and there was a 1027 Hearing. The CHN were not physically removed because the SM sent the CHN to the MGM out of state on or about 7/21/20. The Family Court entered an interim ruling of restrictive remand that the CHN remain with the MGM pending conclusion of the 1027 Hearing. The Family Court believed it would be beneficial to do HIPAA's. On 9/3/20, the 1027 Hearing concluded. The CHN were returned to the care of the SM with ACS supervision. An adjournment in contemplation of dismissal (ACD) occurred. The terms of the ACD was: the SM was to cooperate with ACS supervision including announced and unannounced visits, SM was to ensure the CHN's medical needs were met including ensuring they have regular Dr.'s visits and their medication was kept up to date, the SM to ensure that the children's educational needs are met, including ensuring the school-aged children attend school regularly and on time, the SM was to continue to cooperate with PPRS, the SM was to continue with individual therapy, the SM was to cooperate with reasonable referrals for services, the SM was to sign any necessary HIPPAS to confirm compliance with these orders, and the SM was to continue to comply with Homemaking services.

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