Child Fatality Report

Report Identification Number: NY-17-058

Prepared by: New York City Regional Office

Issue Date: Nov 28, 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	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		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 06/17/2017
Initial Date OCFS Notified: 06/17/2017

Presenting Information

The 6/17/17 reports alleged that the SM was the BM of the 2-month-old SC, and 6-year-old, 10-year-old, 13-year-old, and 16-year-old SS. The reports alleged the SM gave conflicting stories about finding SC the morning of 6/17/17. The SM stated she fell asleep with the SC in her arms. The SM woke up on 6/17/17 and the SC was under her. The SM found the SC face down on the pillow bleeding from his nose. The SM gave the SC CPR and then the 13-year-old also performed CPR on the SC. The SM's other story was that she fed the SC and put him in the playpen at 10:00 P.M. on 6/16/17. The SM stated that when she woke up the SC was next to her. The SC was taken to the hospital and pronounced dead at 11:45 A.M. The SM reeked of alcohol. The SC's death was deemed suspicious. There was no information regarding the other children in the home.

Executive Summary

The 2-month-old male child (SC) died on 6/17/17. NYCRO received the ME's final report on 11/13/17. The ME listed the cause of death as positional asphyxia associated with prone position and bed sharing in adult bed and the manner of death as accident.

The allegations of the 6/17/17 report were DOA/Fatality, PD/AM and IG of the SC by the SM.

ACS obtained information from the Investigative Consultant (IC), LE, EMS, medical professionals, and family members, including the SM and adult half-sibling.

ACS met with St. John's Hospital medical and social work staff to obtain accounts of the incident. The attending physician said the SC did not have pre-existing medical conditions and there were no visible marks or bruises found. The physician had not obtained an account from the SM; however, the social work staff had observed SM's interview with LE. ACS learned that the SM cleaned and fed the SC and put him to bed (in his pack and play) at 10:00 P.M. The SM woke up on her left side on top of the SC the morning of 6/17/17. The SM observed the SC lying face down with blood coming out of his nose and mouth. She admitted drinking Brandy alcohol from 5:00 P.M. to 6:00 P.M. and again from 8:00 P.M. to 9:00 P.M.

During the ACS interview, it was reported that the SM left the home on 6/16/17 to meet friends. The SM reported that during the period she was out of the home, she drank four to five 8 ounce cups of Brandy and soda. The SM said she returned home at 5:00 P.M. She said she fed the SC 6 ounces of formula and placed him in the pack and play to sleep at 10:00 P.M. The SM reported that the SC usually slept from 10:00 P.M. through 5:30 A.M. The SM said the 13-year-old SS placed the SC alongside the SM in the bed after the SC was unable to stop crying. The SM reported falling asleep on her queen sized bed after watching television and waking up at 11:00 A.M. on 6/17/17. The SM observed the SC was in a face down position underneath her arm with a bloody nose. The SM attempted CPR; however, she was unsuccessful at her attempts to resuscitate the SC. The SM said she directed the SS to call 911. During the SM‘s interview ACS did not discuss whether the SM was educated about safe sleep practices.

The adult half-sibling said he supervised the SC and the surviving half-siblings on 6/16/17, while the SM was out of the home. The adult-half sibling said the SM was drinking while out, and could smell the alcohol on her when she returned home; however, she did not appear intoxicated. The adult half-sibling reportedly observed the SC around 10:00 P.M. (when the SM placed the SC in his pack and playpen). The adult half-sibling left the home on 6/17/17 at 7:00 A.M.

ACS interviewed the half-siblings who revealed they did not know what occurred on 6/16/17 and could not provide an account. A minor male half-sibling said the SM co-slept with the SC at times. The half-siblings denied witnessing the SM impaired or under the influence of alcohol while in their presence.

ACS convened an Initial Child Safety Conference on 6/21/17 to discuss the case circumstances and safety concerns of the half siblings. ACS discussed the influence of alcohol on SM's ability to care for the half-siblings. ACS sought a remand of the half-siblings through Queens County Family Court (QCFC).

As of 11/28/17, ACS had not yet completed the investigation that began on 6/17/17. ACS opened the Family Services Stage of the case on 6/20/17 to monitor and provide foster care services to the family. As of 11/28/17, the half-siblings remained with relative resources and in foster care placement.

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?** 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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
N/A

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

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

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

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Failure to provide safe sleep education/information
Summary:	ACS did not document providing the SM with safe sleep education/information during the 6/17/17 investigation.
Legal Reference:	13-OCFS-ADM-02
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:	There was no documentation in the progress notes that the ACS contacted the physician to obtain information about the half-siblings' medical needs.
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 will take or took 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:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-day Fatality report was not completed within 30 days of receipt of the report.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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:	ACS did not complete the 7-day safety assessment in a timely manner. The report was dated 6/17/17 and ACS completed the 7-day safety assessment on 6/30/17.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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 24 Hour Assessment
Summary:	ACS did not complete the 24-hour assessment within the required timeframe.
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 will take or took 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: 06/17/2017 **Time of Death:** 11:45 AM

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

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 10:44 AM
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☒ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	37 Year(s)
Deceased Child's Household	Other Child - Half Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Other Child - Half Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Other Child - Half Sibling	No Role	Female	16 Year(s)
Deceased Child's Household	Other Child - Half Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Other Child - Half Sibling	No Role	Male	17 Year(s)
Other Household 1	Other Child - Half Sibling	No Role	Male	9 Year(s)
Other Household 2	Other Child - Half Sibling	No Role	Male	10 Year(s)
Other Household 3	Adult Sibling	No Role	Male	20 Year(s)

LDSS Response

On 6/17/17, the ACS Instant Response Team (IRT) found that the 3-month-old SC was located at Saint John's Hospital. An IRT Specialist spoke with the attending physician and learned that the SC was found face down by the SM. The SM reported to the hospital staff that she last saw the SC at 10:00 P.M. on 6/16/17. The SM stated she placed the SC in the pack and play while she went to sleep in her queen sized bed. The SM woke up and observed she was lying on her left side on top of the SC. The SC was brought to the hospital at 11:00 A.M. on 6/17/17 and was pronounced dead at 11:45 A.M. ACS learned that the SM smelled of alcohol.

ACS, Emergency Children's Services (ECS) visited the hospital to interview the SM; however, ECS was unsuccessful. Thereafter, ECS visited the case address and was not allowed entry into the home as LE had deemed the case address was a crime scene. The surviving half-siblings were reportedly with an uncle. ECS learned that two of the half-siblings who resided with the SM were not in the home at the time of the incident involving the SC's death.

ACS contacted the ME on 6/17/17 and was informed that the SM and a half sibling reported conflicting stories. The SM denied being intoxicated although alcohol was smelled on her breath. ACS made a follow-up telephone call to the ME on 6/19/17. The ME reported that a preliminary review revealed no findings.

On 6/17/17, ACS contacted LE who stated the SM appeared to be intoxicated. ACS conducted an emergency removal of the SC's half-siblings.

On 6/18/17, the ACS Specialist interviewed the SM at the precinct. The SM said she used alcohol on 6/15/17, and left the subject children with the adult half-sibling. The SM denied having a substance abuse history. ACS did not ask the SM about her knowledge of safe sleep practices.

On 6/19/17, ACS consulted with the Investigative Consultants to obtain a criminal record background check for the SM. ACS learned that LE did not file criminal charges and were awaiting autopsy reports and further information. ACS spoke with and identified a family resource to care for three of the SC's half-sibling's. ACS found that the SC's 9-year-old male half-sibling resided with a maternal great aunt (MGA) and a 10-year-old half-sibling with a maternal cousin through voluntary family arrangements. These two children resided out of New York City's jurisdiction.

On 6/21/17, the ACS Specialist interviewed the SC's adult half-sibling regarding the events that occurred on 6/17/17 (the adult half sibling was reportedly babysitting the SC and half-siblings prior to the SM's return home). ACS held a Child Safety Conference at the Queens Borough office and recommended the SM engage in substance treatment, DV/Family violence counseling, bereavement services and parenting.

On 6/21/17, ACS spoke with the EMS liaison who said two EMS units were dispatched to the home on 6/17/17 at 10:44 A.M. and 10:49 A.M., respectively. EMS attempted CPR and transported the SC to St. John's Hospital.

On 6/22/17, ACS filed an Article Ten Petition in QCFC. The 16-year-old and 17-year-old half siblings were paroled to the SM with conditions that the SM refrain from alcohol use. A third half-sibling was released to the maternal aunt with supervised visits at the agency's discretion. The judge remanded the three youngest half-siblings to the care and custody the ACS Commissioner (supervised visits with agency discretion).

On 6/23/17, ACS assessed the home and observed a queen sized bed and a pack and play in the SM's bedroom. ACS observed there were no batteries in the smoke and carbon detectors and counseled the SM about obtaining batteries for the devices. There was an ample amount of food in the home.

On 6/28/17, ACS learned that the SM appeared under the influence of alcohol during LE's home visit. LE did not observe CHN in the home on 6/28/17. On 6/29/17, the SM was arrested for endangering the welfare of a child.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041861 - Deceased Child, Male, 2 Mons	041872 - Mother, Female, 37 Year(s)	DOA / Fatality	Pending
041861 - Deceased Child, Male, 2 Mons	041872 - Mother, Female, 37 Year(s)	Parents Drug / Alcohol Misuse	Pending
041861 - Deceased Child, Male, 2 Mons	041872 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Pending

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?	☒	☐	☐	☐

Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ACS did not contact the doctor to obtain information about the children's health status.

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?	☒	☐	☐	☐
Explain: During the 6/17/17 investigation, ACS did not complete/approve the 24-hour, 7-day and 30-day safety assessments within the required timeframes.				

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
ACS filed an Article Ten Neglect petition in the QCFC and was advised to return to court on 6/22/17. On 6/22/17, two of the half-siblings were paroled to the SM with conditions that the SM refrain from alcohol use. A third half-sibling was released to the maternal aunt with supervised visits at the agencies discretion. ACS obtained a remand, for the three youngest half-siblings and they were placed in kinship foster care.

Legal Activity Related to the Fatality

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

☒Family Court ☒Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/22/2017	There was not a fact finding	There was not a disposition
Respondent:	041872 Mother Female 37 Year(s)	
Comments:	ACS filed an Article Ten Neglect petition in the QCFC on behalf of the surviving half-siblings naming the SM as the respondent.	

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	Biological Mother	Pending	The Disposition is pending.
Comments:	The SM was arrested on 6/29/17, and charged with endangering the welfare of a child.		

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 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: The family received foster care services and COS.							

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 half-siblings were provided with foster care services, support from relative resources and bereavement counseling to support their well being.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM was referred to substance use counseling, bereavement counseling, parenting and mental health counseling.

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? 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
- ☒ 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)
03/31/2014	Other Child - Half Sibling, Female, 10 Years	Mother, Female, 33 Years	Lack of Medical Care	Unfounded	Yes
	Other Child - Half Sibling, Female, 3 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	
	Other Child - Half Sibling, Male, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	
	Other Child - Half Sibling, Male, 7 Years	Mother, Female, 33 Years	Educational Neglect	Unfounded	
	Other Child - Half Sibling, Male, 7 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Other Child - Half Sibling, Male, 7 Years	Mother, Female, 33 Years	Lack of Medical Care	Unfounded	
	Other Child - Half Sibling, Male, 12 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	
	Other Child - Half Sibling, Male, 14 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	
	Other Child - Half Sibling, Male, 12 Years	Mother, Female, 33 Years	Lack of Medical Care	Unfounded	
	Other Child - Half Sibling, Male, 7 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	
	Other Child - Half Sibling, Female, 10 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 3/31/14 SCR report alleged that the BM was the caretaker for her female child (age 2), male child (age 5), female child (age unknown), male child (age 13) and male child (age 7). The report also alleged that the male child, age 7, had

special needs, and emotional and aggressive behaviors. The 7-year-old child was on medication and it was unknown whether he received his medication. He was not in school for the six days prior to 3/31/14. The SM did not make a plan for his care and his whereabouts were unknown.

Determination: Unfounded	**Date of Determination:** 06/02/2014

Basis for Determination:
The 3/31/14 report was unfounded and the allegations of EdN, IG, IF/C/S, and LMC of the SC by the SM were unsubstantiated. ACS gathered information through collateral contacts with the Department of Homeless Services and the Department of Education. The ACS Specialist documented that the SM provided the children with the basic needs of food, clothing, shelter and attempted to enroll the children in school, but was unable to because the SM needed a letter of residence. ACS did not find credible evidence to substantiate the allegations against the SM.

OCFS Review Results:
NYCRO's review revealed the 3/31/14 investigation was not thorough as ACS did not contact the Dr. or follow up concerning the allegation pertaining to the half-sibling's school enrollment as alleged in the report. The case documentation did not reflect follow up casework activity regarding supervisor directives or recommendations stemming from recent investigations. The children's interview assessments were repetitive and the RAP was inaccurate.

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

Issue:
Adequacy of Progress Notes
Summary:
ACS did not adequately document information in CONNECTIONS progress notes. The SC/CHN interview assessments documented on 5/29/14, appeared repetitive.
Legal Reference:
18 NYCRR 428.5
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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 ACS Specialist did not document medical contact of the SC/CHN medical doctors.
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 will take or took 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/Supervisor Review
Summary:
The 3/31/14 investigation lacked thorough CPM directives or assessments; the case was listed as an HR 13.
Legal Reference:
18 NYCRR 432.2(b)(3)(v)
Action:

ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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:
The 3/31/14 investigation, SC/CHN assessments were repetitive. The ACS Specialist did not follow-up with the SC's educational services although, the ACS Specialist Supervisor directed the Specialist to ensure the services to meet the SC's needs were in place.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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 Risk Assessment Profile (RAP)
Summary:
The RAP assessment was inaccurate. The RAP assessment question 4 listed the family as having, no recent history of housing or unstable housing; however, ACS documented that the family was in a shelter. The family was also in a shelter in 2012.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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:
ACS did not comply with timeliness and content requirements for progress notes. There were progress notes with entry dates that were 30 days or more after the event date.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took 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)
02/09/2014	Other Child - Half Sibling, Male, 12 Years	Mother, Female, 33 Years	Lack of Supervision	Unfounded	Yes
	Other Child - Half Sibling, Female, 10 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unfounded	

Other Child - Half Sibling, Female, 10 Years	Mother, Female, 33 Years	Lack of Supervision	Unfounded
Other Child - Half Sibling, Male, 12 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unfounded
Other Child - Half Sibling, Female, 10 Years	Mother, Female, 33 Years	Sexual Abuse	Unfounded
Other Child - Half Sibling, Male, 12 Years	Mother, Female, 33 Years	Sexual Abuse	Unfounded

Report Summary:
The 2/9/14 SCR report alleged that the 12-year-old male child had been sexually abusing the 10-year old female child by "humping" her over her clothes in a sexual manner. The sexual touching took place on three different occasions. The SM was made aware after the first incident; however, she waited until after the third incident to take any action to protect her daughter. The most recent incident occurred on 2/7/2014.

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

Basis for Determination:
The 2/09/14 report was unfounded and the allegations of LS, SA, IG, of the CHN by the SM were unsubstantiated. The Suffolk County staff gathered evidence through collateral contacts with LE, medical and school staff. The Suffolk County staff documented that the children denied that the male SC sexually abused the female SC. The SM reported the incidents, and contacted a local hospital. There was no credible evidence to substantiate the allegations against the SM.

OCFS Review Results:
NYCRO's review revealed the 2/09/14 investigation was not thorough as Suffolk County DSS did not include documented visits to the siblings home who resided at a different address than the SM, and SC/CHN. The RAP was inaccurate as it included a "No" response instead of "Yes" for the element that assessed the impact of the SM's alcohol use on the family within the past two years. The assessment did not include information from a report dated 5/18/12, that reflected substantiated allegations of PD/AM by the SM.

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

Issue:
Adequacy of Child Protective Services casework contacts

Summary:
Suffolk County DSS did not include a documented home visit for the siblings, who resided at a different address than the SM, and subject children.

Legal Reference:
432.2(b)(4)(vi)

Action:
The Suffolk County LDSS must meet with the staff involved in this fatality investigation and inform SVRO of the date of the meeting, who attended, and what was discussed. The Suffolk County LDSS must submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP was inaccurate as the impact of the SM's alcohol use on the care she provided the children within the more recent two-year period was not assessed in the documentation. In report dated 5/18/12, the allegations of PD/AM of SM had been substantiated.

Legal Reference:
18 NYCRR 432.2(d)

Action:

The Suffolk County LDSS must meet with the staff involved in this fatality investigation and inform SVRO of the date of the meeting, who attended, and what was discussed. The Suffolk County LDSS must submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

Between 2006 and 2012, the SM was known to the SCR in a total of eight reports. The allegations of the reports were IG, I/F/C/S, PD/AM, SA, LMC, XCP, and LS of the half-siblings by the SM. Four of the eight reports were indicated. These reports were dated 3/20/08, 3/09/09, 1/2/12, and 3/22/12. Two of the eight reports were unfounded, and two were suspended and merged into ongoing investigations, respectively. These reports were dated 12/12/06, 1/07/12, 4/24/12, 10/13/06, and 12/3/12. The SM was listed as having Confirmed and Non-Confirmed subject roles.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

Preventive Services History

Per the ACS case record, the SM and half-siblings received preventive services between 2006 and 2013. ACS opened the Family Services Stage to provide case management services to address the SS's mental health and developmental needs, and the SM's alcohol misuse and housing needs. The family received preventive services from Bronx Works (2013), Catholic Services (2012) and the Women's Prison Association (2008). In 2009 the subject family was referred to the ACS Family Preservation Program. The subject family received Department of Homeless Services, case management and early intervention services. In 2012 the SM received Court Ordered Supervision through ACS.

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

Additional Local District Comments

There are no additional Local district comments.

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