Child Fatality Report

Report Identification Number: NY-17-093

Prepared by: New York City Regional Office

Issue Date: Mar 16, 2018

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 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 09/13/2017
Initial Date OCFS Notified: 09/19/2017

Presenting Information

On 9/19/17, the SCR registered a report indicating the SC had a history of chronic asthma and the mother was not consistent with refilling his prescriptions. The report alleged the mother and her boyfriend often smoked marijuana and K2 in the home which exacerbated the SC's condition. The report also alleged that on 8/21/17, the mother and her boyfriend were smoking marijuana and K2 in the home. The SC had an asthma attack and the mother delayed calling 911. The mother did not have medicine in the home as she had failed to fill the prescription. The report alleged that as a result of not having the medication and the delay in seeking medical care the SC went into cardiac arrest and then into a coma. The SC was taken to the hospital and placed on a ventilator. On 9/13/17, the SC was taken off the ventilator and passed away. The report also noted that in August the SC had a medical condition for which the mother failed to seek medical care timely and this caused the SC's face to swell.

Executive Summary

The SC was 2 years old when he died on 9/13/17. The SC's body was referred to the ME for cremation; no autopsy was conducted. According to the medical staff and the death certificate, the SC's cause of death was due to respiratory failure and the manner of death was natural.

The parents had an extensive history of domestic violence (DV) and there were several active orders of protection (OOP) issued against the father on behalf of the mother and the children. The family had an open investigation dated 7/14/17 and an active court case with the Family Court. During the 7/14/17 and the fatality report, the father continued to harass and assault the mother; therefore, there was ongoing concern about the family's safety.

The SC had a respiratory condition and was having problems breathing from 8/19/17 through 8/21/17. The mother reported she was treating the SC on her own, but based on her account she did not have all the prescribed medication or equipment with her when the SC began to get sick. On 8/21/17, the SC woke up coughing and having difficulty breathing. At about 1:30 A.M., the mother attempted to administer a nebulizer treatment to the SC. He did not sit still and she called 911. EMS transported the SC to the hospital where he was placed on a ventilator. On 9/13/17, the SC was taken off the ventilator and pronounced dead.

On 9/15/17, ACS filed an Article 10 Neglect Petition at the Bronx Family Court on behalf of the sibling and named the father as a respondent due to DV issues. ACS was granted court ordered supervision and a stay away OOP was issued against the father on behalf of the mother and the sibling.

On 9/19/17, the SCR registered a report concerning the death of the SC. The allegations of the report were DOA/FATL, LMC, PD/AM of the SC by the mother and her boyfriend; and LMC and IG of the sibling by the mother. The documentation did not support the boyfriend was a person legally responsible (PLR) for the children or a secondary caretaker.

ACS initiated the investigation timely and assessed the sibling was safe in the care of the mother. The two were staying in the home of the MA as the father made several threats to hurt the mother after the death of the SC.

The medical staff had no suspicion concerning the death of the SC as he died at the hospital. It is not clear how much of the mother's account was discussed with the medical staff or the SC's pediatrician. The mother had history of not filling

the SC's prescriptions. In addition, the mother delayed returning to the home over the weekend to have access to the SC's nebulizer and did not reach out for a medical consultation as the SC was congested and had problems breathing for three consecutive days. The mother did not have access to the SC's nebulizer until late evening on 8/20/17.

On 11/18/17, ACS unsubstantiated the allegations against the mother and her boyfriend. ACS cited there was "not sufficient evidence" as opposed to considering there was "some credible evidence" to support allegations.

ACS had credible evidence to substantiate the allegations of LMC and IG against the mother for the sibling as the allegations had already been substantiated in the 7/14/17 investigation. Based on the documentation, the boyfriend was not a PLR. There were no allegations added to the report for the father.

On 11/28/17, the mother was referred to PPRS for DV services, drug screening, and counseling. Although the mother was not initially complying ACS continued efforts to contact the family and persuaded the mother to accept the services.

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?** 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?** No

Explain:
ACS did not utilize relevant information gathered throughout the investigation when making a determination.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	ACS selected safety decision #1 which noted there were no safety factors; however, this was not consistent with the case circumstances.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan 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:	ACS noted there was no secondary caretaker; but, the comments regarding the alcohol and drug use were about the mother's boyfriend and did not focus on the mother. Some responses to the questions listed were not addressed during the investigation.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	ACS selected safety decision #1 which noted there were no safety factors; however, this was not consistent with the case circumstances.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS had sufficient information to add the father as a subject and did not do so. The family history reflected that the father's violent behavior had caused the family to have unstable housing and placed the children at risk of serious harm.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	ACS made relevant collateral contact concerning the SC's medical issues; however, the documentation did not reflect that ACS discussed the events leading to the SC's hospitalization and subsequent death.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/13/2017 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 08/21/2017
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Year(s)

LDSS Response

The mother had a history of substance abuse and neglect of the children's medical care. ACS found the children's basic medical needs (immunizations) were up to date. At the inception of the initial report, ACS had to prompt the mother to address other medical issues. The sibling had a skin condition that the mother neglected and impacted on his school attendance. In addition, prior to the fatality, ACS found the mother did not fill the SC's prescriptions timely and had expired medication in the home.

Medical providers and ACS' medical consultant found the mother had all the medications for the SC and there was no indication she was not administering the medication as required. This response did not consider the mother's account of the events leading up to the SC's hospitalization as according to the mother, the SC was having difficulty breathing from Saturday 8/19/17 through Monday 8/21/17.

The mother reported she allowed a paternal cousin to take the children to a family reunion on 8/19/17. The cousin dropped the children off at the MA's home between 7:00 P.M. and 8:00 P.M. When the mother arrived at the MA's home at about 9:00 P.M., the SC was breathing "fast" so she gave him two pumps from his inhaler. The mother stayed overnight with the children at the MA's home.

On 8/20/17, the SC again exhibited difficulty breathing and the mother gave him two more pumps. The SC was coughing and sounded congested. The mother said she used steam from the bathroom to make him "feel better". The mother said the SC was fine throughout the rest of the day and stayed at the MA's home until 9:30 P.M. The mother arrived at her home at 10:30 P.M. and the SC's condition "started to act up again". The mother gave the SC a nebulizer treatment and place him to sleep between 11:20 P.M. and 11:30 P.M. At 1:30 A.M., the SC woke up coughing as the boyfriend arrived at the home. The mother attempted to administer another treatment with the nebulizer, but the SC did not sit still. The mother called 911, but the boyfriend ran out of the home with the SC because he believed EMS was taking too long to arrive. The mother and the boyfriend met the EMS ambulance and were transported to the hospital. Although the mother had medication in the home, she did not have it at hand on 8/19/17 and did not go home early on 8/20/17 to have access to the SC's nebulizer.

The boyfriend and the mother denied smoking marijuana on the day of the incident.

On 10/24/17, ACS held a Child Safety Conference based on the concerns of the mother's drug use and her failure to follow through with the PPRS referral. ACS determined the mother should be added to the neglect petition filed on 9/15/17. ACS noted that although the mother was not a respondent in the court case, the judge had ordered that she participate or complete "particular services" to increase her protective capacity of the sibling. FCLS delayed ACS' recommendation stating there was no evidence to support the mother's inability to care for the sibling as she was meeting all of his needs. FCLS determined there was no suspicion regarding the mother's ability to care for the sibling. There was no documentation to reflect consideration given to the fact that on 9/12/17, ACS indicated allegations of PD/AM, LMC, and IG of the sibling by the mother.

The main concern throughout the investigations was the parents' history of DV which created an unsafe situation for the family. The father assaulted the mother in August 2017 and January 2018, and is currently incarcerated for Assault and the violation of the OOP.

ACS unfounded the 9/19/17 based on the mother's actions after the report was made to the SCR and not what occasioned the registering of the report by the SCR.

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: Hospital physician

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041041 - Deceased Child, Male, 2 Yrs	041042 - Mother, Female, 31 Year(s)	Lack of Medical Care	Unsubstantiated
041041 - Deceased Child, Male, 2 Yrs	041042 - Mother, Female, 31 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
041041 - Deceased Child, Male, 2 Yrs	041043 - Mother's Partner, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
041041 - Deceased Child, Male, 2 Yrs	041043 - Mother's Partner, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
041041 - Deceased Child, Male, 2 Yrs	041042 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
041041 - Deceased Child, Male, 2 Yrs	041043 - Mother's Partner, Male, 35 Year(s)	Lack of Medical Care	Unsubstantiated
041041 - Deceased Child, Male, 2 Yrs	041042 - Mother, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
041041 - Deceased Child, Male, 2 Yrs	041043 - Mother's Partner, Male, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
041044 - Sibling, Male, 3 Year(s)	041042 - Mother, Female, 31 Year(s)	Lack of Medical Care	Unsubstantiated
041044 - Sibling, Male, 3 Year(s)	041042 - Mother, Female, 31 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?	☒	☐	☐	☐
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?	☒	☐	☐	☐

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:
The 24 hour and 7 day safety assessments reflected there were no safety factors; which was not the case. No 30-Day safety assessment was not completed.

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:
ACS' comments for the questions in the RAP were concerning the boyfriend who was not a PLR or a secondary caretaker.

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: 09/15/2017	**To:** Unknown
Explain: This OOP was issued by the Bronx Family Court and is active.	

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:
ACS offered the mother bereavement, DV services and drug treatment and referred the mother for preventive services. However, as of 2/23/18 the mother was not complying with these services.

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? N/A
Explain:
The SC died on 9/13/17 and ACS offered bereavement counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The SC died on 9/13/17 and ACS offered the mother bereavement counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? Yes

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)
07/14/2017	Sibling, Male, 3 Years	Other Adult - Mother's boyfriend, Male, 26 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	Deceased Child, Male, 2 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Deceased Child, Male, 2 Years	Other Adult - Mother's boyfriend, Male, 26 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Sibling, Male, 3 Years	Mother, Female, 27 Years	Lack of Medical Care	Indicated	
	Sibling, Male, 3 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Sibling, Male, 3 Years	Mother, Female, 27 Years	Inadequate Guardianship	Indicated	

Sibling, Male, 3 Years	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Indicated
Deceased Child, Male, 2 Years	Mother, Female, 27 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 2 Years	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Indicated

Report Summary:
Three reports were registered with the SCR. The reports alleged the mother's drug use was impacting negatively on her ability to care for the children's special needs.

ACS had to prompt the mother to follow up on the SC's current medical needs. The SC had a respiratory condition for which the mother had expired medication in the home. The SC had difficulty breathing from 8/19/17 through 8/21/17. The mother did not have access to his nebulizer until 10:30 P.M. on 8/20/17. The SC was admitted to the hospital on 8/21/17 and went into a coma. He died on 9/13/17.

The parents had issues on DV and an active OOP.

Determination: Indicated | **Date of Determination:** 09/12/2017

Basis for Determination:
The allegations of PD/AM, LMC and IG were substantiated for the children against the mother.

ACS cited the mother admitted to smoking marijuana prior to the SC's hospitalization and tested positive. ACS cited there was a possibility the mother was smoking on the evening of the incident.

ACS cited the mother was not meeting the minimal degree of care for the children. ACS cited the sibling was not receiving school based services as the mother had not obtained medical clearance.

The allegation of IF/C/S was unsubstantiated. ACS cited there was food and clothes for the children, and the boyfriend assisted the mother with the supervision of the children.

OCFS Review Results:
The documentation was not focused on the allegations or facts revealed during the investigation. There were ongoing issues of DV by the father who was not added to the report. The father was harassing and threatening to hurt the mother and the sibling. This made their housing situation unstable.

The safety assessments reflected appropriate safety decisions. However, the safety factors selected were not supported by the comments. The RAP listed the boyfriend as a caretaker; however, based on the documentation he was not a PLR. The comments for the questions listed in the RAP were not consistent with the facts documented in the investigation.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
ACS selected an appropriate safety decision, but the factors selected were not supported by the comments.

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

Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The safety decision was appropriate, but the safety factors selected were not supported by the comments.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Appropriateness of allegation determination
Summary:
ACS did not add allegations of IG and IFCS of the children by the father due to the DV.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan 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 listed the boyfriend as a caretaker; however, based on the documentation gathered, he was not a PLR. Several comments for the questions listed in the RAP were not consistent with the facts documented in the investigation.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to provide notice of report
Summary:
The NOE was not issued to the boyfriend who was listed as the subject of this report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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

07/13/2015	Deceased Child, Male, 4 Months	Mother, Female, 29 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 20 Months	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Sibling, Male, 20 Months	Mother, Female, 29 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 4 Months	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:
The report noted concerns of the mother's use of marijuana. It was alleged the sibling sustained a swollen knot on his head as a result of her drug use. The mother indicated the sibling fell while in the park and denied she was using drugs.

The father had recently been arrested and released for a violation of an OOP. The mother reported she fled the home because he began kicking the door and threatened her. The mother reported the violation to the police and went to a shelter with the children. The parents had been married for about a year; it was not clear whether they were married after the issuance of the OOP.

Determination: Unfounded | **Date of Determination:** 09/11/2015

Basis for Determination:
The determination narrative to support the unsubstantiation of PD/AM was based on "no sufficient credible evidence" as opposed to "no credible evidence." There was a difference of opinion between the supervisor and CPS concerning this determination. The narrative was documented in the section where allegations are substantiated. Based on the information gathered, there was "credible evidence' to support the PD/AM. The mother was self-medicating to reduce her stress, tested positive on two random screenings and she was the primary caretaker for the children.

The allegation of IG was unsubstantiated against the mother as she seemed to be providing for the children's basic needs.

OCFS Review Results:
The overall investigation did not reflect the information gathered was utilized in making assessments of the family circumstances. A neighbor and a PA mentioned the parents had contact prior to the incident that lead to the father's arrest for the violation of the OOP. ACS properly assessed the need of relevant services and utilized proper interventions. However, ACS failed to add the father as a subject of the report with allegations of IF/C/S and IG. Based on his actions the family was left homeless and was exposed to violent incidents.

The safety assessments reflected appropriate decisions, but comments to support the safety factors were not concise as to the case circumstance.

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
The safety decision selected for the 7-day and the determination safety assessments noted the children were in immediate and impending danger of serious harm. However, interventions were initially put in place that reduced the safety concerns pertaining to the domestic violence. The comments did not support the selected safety factors nor considered the actions taken.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan 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:
ACS listed the parents as the caretakers of the children, but focused the comments on the mother. Questions concerning the father were not properly answered as they did not take into consideration his violent behavior and the fact that he was not properly caring for the children.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Appropriateness of allegation determination
Summary:
ACS did not add and substantiate the allegations of IF/C/S and IG for the father although his actions caused the family to be homeless and to be exposed to violent incidents.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to provide notice of report
Summary:
The Notice of Existence was not issued to the father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
ACS did not fully explore the mother’s consistency with enforcing the OOP issued in 2014, due to expire in 2019. Collaterals noted the parents were seen together with the children prior to the violation of the OOP.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/27/2014	Other Child - Half sibling, Female, 4 Years	Father, Male, 55 Years	Inadequate Guardianship	Indicated	No
	Other Child - Half sibling, Female, 5 Years	Father, Male, 55 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 5 Months	Mother, Female, 28 Years	Inadequate Guardianship	Indicated	
	Other Child - Half sibling, Female, 5 Years	Mother, Female, 28 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 5 Months	Father, Male, 55 Years	Inadequate Guardianship	Indicated	
	Other Child - Half sibling, Female, 4 Years	Mother, Female, 28 Years	Inadequate Guardianship	Indicated	

Report Summary:
This report was registered with the SCR and assigned to Broome County LDSS. The report alleged there was a physical incident between the parents in the presence of the children. The family had just moved to Broome County. LDSS learned the parents had a history of DV and an OOP that expired in 2012. The father had two children from a prior relationship in his physical custody. The parents initially denied they had a physical altercation. However, on 5/14/14, they were involved in a physical altercation which involved police intervention. The father fled with the two half siblings; their whereabouts were unknown. A warrant was issued for the father.

Determination: Indicated **Date of Determination:** 06/16/2014

Basis for Determination:
LDSS substantiated the allegation of IG of the children by the parents. The LDSS based their decision on the parents' action in which they engaged in verbal and physical altercations in the presence of the children.

OCFS Review Results:
LDSS conducted a thorough investigation and took appropriate actions as needed. LDSS completed safety contracts with the parents. LDSS had legal consultations and clearly provided summaries of the case events. After the 5/14/14 incident, LDSS determined that a neglect petition was necessary. However, the father's whereabouts were unknown. LDSS corroborated with the police to locate the half siblings; to no avail. LDSS planned to file a neglect petition on behalf on the half siblings once located.

LDSS addressed the issue of co-sleeping and provided a pack-N-play for the infant. Also safe sleep information and other provisions were provided for the infant as well as DV resources.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/14/2014	Sibling, Male, 49 Days	Mother, Female, 28 Years	Lack of Supervision	Unfounded	Yes

Other Child - Half sibling, Female, 4 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded
Other Child - Half sibling, Female, 4 Years	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unfounded
Other Child - Half sibling, Female, 3 Years	Mother, Female, 28 Years	Lack of Supervision	Unfounded
Sibling, Male, 49 Days	Father, Male, 55 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 49 Days	Father, Male, 55 Years	Parents Drug / Alcohol Misuse	Unfounded
Other Child - Half sibling, Female, 4 Years	Father, Male, 55 Years	Parents Drug / Alcohol Misuse	Unfounded
Other Child - Half sibling, Female, 3 Years	Father, Male, 55 Years	Parents Drug / Alcohol Misuse	Unfounded
Other Child - Half sibling, Female, 3 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded
Other Child - Half sibling, Female, 3 Years	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unfounded
Sibling, Male, 49 Days	Father, Male, 55 Years	Sexual Abuse	Unfounded
Sibling, Male, 49 Days	Father, Male, 55 Years	Lack of Supervision	Unfounded
Other Child - Half sibling, Female, 4 Years	Father, Male, 55 Years	Inadequate Guardianship	Unfounded
Other Child - Half sibling, Female, 4 Years	Father, Male, 55 Years	Lack of Supervision	Unfounded
Other Child - Half sibling, Female, 3 Years	Father, Male, 55 Years	Inadequate Guardianship	Unfounded
Other Child - Half sibling, Female, 3 Years	Father, Male, 55 Years	Lack of Supervision	Unfounded
Sibling, Male, 49 Days	Mother, Female, 28 Years	Inadequate Guardianship	Unfounded
Sibling, Male, 49 Days	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unfounded
Other Child - Half sibling, Female, 4 Years	Mother, Female, 28 Years	Lack of Supervision	Unfounded

Report Summary:
Three reports were registered with the SCR and merged. The reports alleged the father had inserted his fingers in the sibling's rectum and told the mother during an argument. The mother said the father became angry after she told him that one of the half siblings took the 5-month-old sibling out of the bassinet and placed him on the bed. The mother disclosed she and the father had a history of physical and verbal altercations. The mother went to a shelter because she did not feel safe. The mother indicated that the father would ask her to leave the home whenever they had an altercation. The father was arrested and released after the infant was medically cleared.

Determination: Unfounded | **Date of Determination:** 03/16/2014

Basis for Determination:
The allegations unsubstantiated, but were not addressed individually for each child as it pertained to each subject.

ACS unsubstantiated the allegation of SA against the father based on a medical examination.

ACS unsubstantiated the allegation of PD/AM citing there was no evidence and the parents refused to submit to a drug screening.

The allegations of L/S and IG were unsubstantiated noting that "although the parents argued in the home in the children's presence, there were no physical altercations in the home. ACS cited the family resided in a studio; therefore, there was always someone present to watch the children.

OCFS Review Results:
This was not a thorough investigation as ACS did not utilize the information gathered to properly assess the risk and safety of the children. ACS made some relevant collateral contacts concerning the parents' ability to care for the children and there were no reported concerns. However, the investigation documentation reflected a lack of understanding of the DV dynamics based on the parents' behaviors and their interviews. The mother left the father's home and went to a shelter, later she left the shelter and married the father. Based on the documentation, ACS minimized the issues of DV. Progress notes were not entered timely.

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

Issue:
Failure to provide notice of report
Summary:
The NOE were not issued for the children's mothers. The father was taking the half siblings' to visit their mother in jail and she was expected to be released within months.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in thisinvestigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Appropriateness of allegation determination
Summary:
ACS did not utilize the information gathered when making the determinations. In addition, ACS did not address each allegation individually for each child as it pertained to each subject.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
The investigation was not thorough. ACS did not utilize the information gathered to properly assess the risk and safety of the children or to make the determination.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Adequacy of Progress Notes
Summary:
Documentation of progress notes were not entered timely and were not qualitative. Several notes were entered over 30 days late. ACS documented information in the progress notes concerning clinical and DV issues, but did not reflect these were fully explored.
Legal Reference:
18 NYCRR 428.5
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Predetermination/Assessment of Current Safety and Risk
Summary:
ACS noted there were no safety factors even though the mother returned to live with the father and the issue of DV was prevalent. In addition, the family intended to move upstate and the PA who was the main support for caring for the half siblings expressed concerns that she would not be able to intervene when the parents engage in altercations.
Legal Reference:
18 NYCRR 432.1(aa)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-Day safety assessment had an appropriate safety decision, but the safety factors and comments were not consistent with the case circumstance. The father's CPS history of indicated cases, DIRs and previous OOP should have been considered .
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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

N/A

Known CPS History Outside of NYS

The family had no known CPS history in NYS.

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